Insurance /Office Policy Information

** PLEASE COMPLETE ENTIRE FORM **

Patient's Information

Last First MI

Patient's Name: ______________________________ Gender: M / F

Patient's Relationship to Insured: Spouse / Child / Self Marital Status: S / M / D / W

Full Time Student: Yes / No (If Yes) Name of School: ______________________ State: _____

Patient's Employer/Occupation: ______________________________

Insured's Name (If Not Self): ______________________ DOB: ___/___/___ Gender: M / F

Insured's Social Security #: ____-____-____ Age: _____ Marital Status: S / M / D / W

Insured's Employer: ______________________ Work Phone #: (____) ____-______

Health Ins. Company: ______________________ (Have copy of insurance card)

Vision Insurance: ______________________ (Have copy of insurance card)

Secondary Insured's Information

Last First MI

Policy Holder's Name: ______________________ DOB: ___/___/___ Gender: M / F

Policy Holder's Social Security #: ____-____-____ Age: _____ Marital Status: S / M / D / W

Insured's Employer: ______________________ Work Phone #: (____) ____-______

Secondary Ins. Comp: ______________________ (Have copy of insurance card)

Notice:

Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies! Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay.

______________________________ ______________

(Signature of Patient or responsible party) Date

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Mario J. Contaldi, O.D.'s "Notice of Privacy Practices" to read.

______________________________ ______________

(Signature of Patient or responsible party) Date