Date:
Patient Name:

Patient ID:

Occupation:

Date of Birth:

Gender:

Address:

Emergency Contact:

E-Mail:

Name:

Home Phone:

Phone:

Cell Phone:

Relationship:

Work Phone:

Please circle your answers to the questions below:

Marital Status: Single/Married/Domestic/Partner/Divorced/Widowed
Race: American Indian/Asian/Black or African American/White/Declines to Specify/Other
Ethnicity: Hispanic or Latino/Not Hispanic or Latino/Declined to Specify/Other
Language: English/Spanish/Portuguese/French/German/Haitian or Haitian Creole/
American Sign Language/Other:(specify)

Referring Doctor/Person:
Primary Care Physician:
Pharmacy:

INSURANCE INFORMATION

Primary: Policy ID#:
Secondary: Policy ID #
Policy Holder (if not patient):
Relationship:

Date of birth:

I hereby authorize Attleboro Ophthalmological Assoc., Inc. to release/furnish any medical or other information to my insurance carrier(s) that is necessary to process claims for services provided to me by Attleboro Ophthalmological Assoc., Inc. Peter M. Fay, M.D., Thomas M. Fay, M.D., and Abby Raposo, O.D. Initial _____

I herby assign to Attleboro Ophthalmological Assoc., Inc. all payments for services rendered to myself or my dependents. I also authorize insurance payments be made directly to Attleboro Ophthalmological Assoc., Inc. for services rendered to myself and my dependents. Initial: _____

I understand that I am personally responsible for providing correct insurance information at the time of service. I understand that I am personally responsible for paying all deductibles and charges incurred at this time or in the future should my insurance deny or otherwise not pay them. Initial: _____

Patient Signature: