Fornara eye center

Welcome

Dr. John D. Fornara, Optometrist

www.fornaraeyecenter.com

Patient Information

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Spouse's / Parent Name _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Occupation _____ Hobbies _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

Primary Insurance

Person Responsible for Account _____ (Last Name) _____ (First Name) _____ (Initial)

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Additional Insurance

Insured Name _____ (Last Name) _____ (First Name) _____ (Initial)

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Assignment and Release

I hereby authorize payment directly to _____ of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. In the event my account is turned over to collection, I understand that I will be responsible for all collection costs. I also understand that once an account has been turned over to a collection agency, services will not be provided by Dr. Fornara until the account is paid in full, and all future visits will be required payment at the time of service on a cash basis.

I authorize the above doctor and/or any provider or supplier of services of this office to release this information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____