

PLEASE PRINT

**GRANBY FAMILY EYE CARE, LLC
355 SALMON BROOK STREET.
GRANBY, CT 06035
860-653-7440**

PATIENT INFORMATION:

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

NAME: _____

ADDRESS: _____

HAVE WE SEEN OTHER FAMILY MEMBERS? _____

CITY _____ ZIP: _____

SEX: () FEMALE () MALE

HOME PHONE: () _____

CELL PHONE: () _____

DOB: ____/____/____ AGE: _____

E-MAIL ADDRESS: _____

SOCIAL SECURITY# _____

MARITAL STATUS: () SINGLE () MARRIED () OTHER

EMPLOYER:

_____ OCCUPATION _____

WORK PHONE: () _____ OK TO CALL WORK? Y N

RESPONSIBLE PARTY FOR INSURANCE (IF DIFFERENT FROM ABOVE)

NAME: _____ SS# _____

DOB: ____/____/____

RELATIONSHIP TO PATIENT _____

PATIENT'S **VISION** INSURANCE (if any): _____

PATIENTS **PRIMARY/MEDICAL** INSURANCE _____

EMERGENCY CONTACT PERSON: _____ PHONE: _____

SIGNATURE FOR PAYMENT / INSURANCE ASSIGNMENT

I HEREBY ASSIGN or AGREE TO PAY TO DR. MOFFA & GRANBY FAMILY EYE CARE, LLC. ALL PAYMENT FOR MEDICAL SERVICES RENDERED TO MY SELF. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES WHETHER OR NOT COVERED BY INSURANCE.** IF COPAYMENTS AND/ OR DEDUCTIBLES ARE DESIGNATED BY MY INSURANCE COMPANY OR HEALTH PLAN, I AGREE TO PAY THEM TO DR. MOFFA AND GRANBY FAMILY EYE CARE, LLC

X _____ DATE: _____

MEDICARE ASSIGNMENT/PAYMENT

I REQUEST PAYMENT OF AUTHORIZED MEDICARE BENEFITS TO ME OR ON MY BEHALF FOR ANY SERVICE FURNISH ME BY DR. MOFFA & GRANBY FAMILY EYE CARE, LLC. I AUTHORIZE ANY HOLDER OF MEDICAL AND OTHER INFORMATION ABOUT ME TO RELEASE TO MEDICARE AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS FOR RELATED SERVICES.

X _____ DATE: _____