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:_____