DR. FRANK DZWIELESKI DR. MATTHEW CORSO

PATIENT NAME _____ AGE _____ TITLE: MR. _____
LAST FIRST M.I. MRS. _____
ADDRESS _____ MS. _____
MISS _____
CITY _____ STATE _____ ZIP _____ DR. _____
REV. _____

HOME PHONE _____ EMAIL ADDRESS _____

DAYTIME PHONE _____ CELL PHONE _____

PLACE OF EMPLOYMENT _____ OCCUPATION_____

EMPLOYMENT STATUS: full time ___ part time ___ unemployed ___ disabled ___ student ___ retired_____

MARITAL STATUS: single ___ married ___ separated ___ divorced ___ widowed _____

SOCIAL SECURITY NUMBER _____ YOUR SEX: MALE _____
FEMALE _____

BIRTHDATE _____ EYE COLOR _____

REFERRED BY _____ HOBBY OR SPORT _____

PERSON RESPONSIBLE FOR PAYMENT IF DIFFERENT THAN ABOVE

NAME _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____

SOCIAL SECURITY NUMBER _____

INSURANCE INFORMATION

INSURANCE NAME _____ INSURED'S NAME _____

INSURED'S EMPLOYER _____ INSURED'S BIRTHDATE _____

SOCIAL SECURITY NUMBER _____ MEDICARE NUMBER _____

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR INSURANCE AND/OR MEDICARE PAYMENT IS TRUE AND CORRECT. I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT OF MY INSURANCE AND/OR MEDICARE BENEFITS, AND I AURTHORIZE PAYMENT OF THESE BENEFITS DIRECTLY TO FAMILY EYE CARE OF NEPA ON MY BEHALF FOR ANY SERVICES AND MATERIALS FURNISHED. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE TO RELATED SERVICES. IF I HAVE OTHER HEALTH INSURANCE COVERAGE (AS INDICATED IN ITEM 9 OF THE HCFA-1500 CLAIM FORM OR ELECTRONICALLY SUBMITTED CLAIM), MY SIGNATURE AUTHORIZES RELEASE OF THE ABOVE MEDICAL INFORMATION TO THE INSURER OR AGENCY SHOWN, AND AUTHORIZES MY DOCTOR TO ACT AS MY AGENT, AS ABOVE. FURTHER, IT IS THE PATIENT'S UNDERSTANDING THAT HE/SHE IS RESPONSIBLE FOR ALL FEES OF FAMILY EYE CARE OF NEPA NOT COVERED BY MEDICAL INSURANCE AND IN THE EVENT THAT A STATEMENT FOR FEES IS NOT PAID WITHIN THIRTY (30) DAYS OF THE DATE DUE, THE PATIENT SHALL BE FURTHER OBLIGATED TO PAY INTEREST ON ANY OUTSTANDING BALANCE AT THE RATE OF 18% PER ANNUM. REVISED FEBRUARY 19, 2003.

ANY KNOWN ALLERGIES _____ MEDICATIONS BEING TAKEN AT THIS TIME _____

_____

PLEASE CHECK THE FOLLOWING IF IT PERTAINS TO YOU

HIGH BLOOD PRESSURE _____ DIABETES _____ ASTHMA _____ HEART COND _____ THYROID _____
FAMILY DOCTOR _____ PHONE _____ PHARMACY USED _____

SIGNATURE _____ **DATE** _____

☐ PARENT/GUARDIAN ☐ POA ☐ CAREGIVER ☐ PATIENT NOT MENTALLY/PHYSICALLY CAPABLE OF SIGNING