See Sharp EYEWEAR

David M. Girardi, OD

Patient Demographic Information

Patient Name: _____ _____ _____ __/__/__
(Last) (First) (M.I.) (DOB)

Patient SSN (Required) _____

Address: _____ _____
(Street) (Apt/PO Box)

_____ _____ _____
(City) (State) (Zip)

Phone: Home (___)_____ Cell (___)_____ Work (___)_____
*May we contact you via Text Messages [] E-mail []

E-Mail: _____@_____ Preferred method of contact: _____

Marital Status: [] Single [] Married [] Divorced [] Partnered [] Other

Employer/School _____ Occupation _____
Emergency Contact _____ Relationship _____ Phone _____

Insurance

*If you have additional insurance coverage, please notify the staff at the front desk.

Primary Medical

Primary Insured _____
Primary Insured DOB _____
Primary Insured SSN _____
Employer _____
Relationship to Patient _____
Insurance Company _____
Member ID _____
Plan Name/Group _____

Vision or Secondary

[] Same as Medical Insurance
Primary Insured _____
Primary Insured DOB _____
Primary Insured SSN _____
Employer _____
Relationship to Patient _____
Insurance Company _____
Member ID _____
Plan Name/Group _____

Doctor and Pharmacy

Primary Care Physician: _____ Phone: (___)_____
Location: _____ Fax: (___)_____

Pharmacy: _____ Phone: (___)_____
Location: _____ Fax: (___)_____

Assignment and HIPAA Release: I certify that I and/or my dependent (Patient), have insurance coverage with the company(ies) listed above and assign directly to Dr. David M. Girardi, OD LLC, all insurance benefits, if any, otherwise payable to myself for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. David M. Girardi, OD LLC may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end one year from the date of signature.
I have been given the opportunity to review HIPAA policies and have either declined to review or was given a copy of HIPAA privacy policies. A copy of our policy and HIPAA information is available upon request at the front desk.

Signature of Patient/Primary Insured:_____ Date:_____

Over