LAST NAME: FIRST: MI: DOB:

ADDRESS: CITY: STATE: ZIP

HOME PHONE# CELL #

MALE: FEMALE: SS#

Gender Identity: Sexual Orientation:

Preferred Pronoun:

E-MAIL: MARITAL STATUS:

I AUTHORIZE DANBURY EYE PHYSICIANS SURGEONS TO COMMUNICATE WITH ME VIA:

a) voicemail to cell phone b) voicemail to home phone

c) e-mail message to my e-mail address above d) text message to my cell phone

EMPLOYER: WORK#

LANGUAGE: (REFUSED) RACE: (REFUSED)

ETHNICITY: (REFUSED).

PRIMARY CARE PHYSICIAN: TEL#:

PHARMACY: ADDRESS: TEL#

NEXT OF KIN: RELATION: TEL#

INSURANCE #1 PLEASE SHOW CARDS ID# SELF/ SPOUSE/PARENT

INSURANCE #2 ID# SELF/SPOUSE/PARENT

I, the undersigned, authorize Danbury Eye Physicians and Surgeons to bill my insurance company for services rendered, and to release information as requested by insurance in order for them to process my bill. I understand I AM RESPONSIBLE FOR OBTAINING A REFERRAL IF REQUIRED BY MY INSURANCE.I UNDERSTAND I AM RESPONSIBLE FOR ALL BALANCES ASSOCIATED WITH NON COVERED CHARGES, DEDUCTIBLES AND CO-INSURANCES AS DICTATED BY MY INSURANCE PLAN. I acknowledge full responsibility for all balances including fees incurred by Danbury Eye Physicians in an attempt to collect those balances.

SIGNATURE OF PATIENT/GUARDIAN. DATE