ADDRESS:  CITY:  STATE:  ZIR  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)  PRIMARY CARE PHYSICIAN:  TEL#:  PHARMACY:  ADDRESS:  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 compan 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 DETAINING A REFERRAL FREQUIRED B MY INSURANCE. UNDERSTAND I AM RESPONSIBLE FOR DETAINING A REFERRAL FREQUIRED B MY INSURANCE. UNDERSTAND I AM RESPONSIBLE FOR ALL BALANCES ASSOCIATED WITH N COVERED CHARGES. DEDUCTIBLES AND CO-INSURANCES AS DICTATED BY MY INSURANCE. JUNDERSTAND I AM RESPONSIBLE FOR ALL BALANCES ASSOCIATED WITH N COVERED CHARGES. DEDUCTIBLES AND CO-INSURANCES AS DICTATED BY MY ENGURED BY INSURANCE. JUNDERSTAND I AM RESPONSIBLE FOR ALL BALANCES ASSOCIATED WITH N COVERED CHARGES. DEDUCTIBLES AND CO-INSURANCES AS DICTATED BY MY ENGURED BY INSURANCE. JUNDERSTAND I AM RESPONSIBLE FOR ALL BALANCES ASSOCIATED WITH N COVERED CHARGES. DEDUCTIBLES AND CO-INSURANCES AS DICTATED BY MY ENGURED BY INSURANCE. JUNDERSTAND I AM RESPONSIBLE FOR ALL BALANCES ASSOCIATED WITH N COVERED CHARGES. DEDUCTIBLES AND CO-INSURANCES AS DICTATED BY MY ENGURED BY INSURANCE. JUNDERSTAND I CO-INSURANCES AS DICTATED BY MY ENGURED BY INSURANCE I SURGED BY INSURANCE I SUR	LAST NAME:	FIRST:		MI:	DOB:	
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