Madison Eye Care, LLC

Maria I. Diaz O.D. Eileen Bush O.D.
1347 Boston Post Road Suite 101 Telephone:203-245-8567
Madison, CT 06443 Fax:203-245-0552

WELCOME TO OUR PRACTICE!

Patient Name_____ Date_____

Date of Birth_____ Sex_____ SSN:_____

Address_____

(Street) (City) (State) (Zip)

Marital Status:_____ If married, spouse's name_____

Home Telephone_____ Other Phone (cell/work)_____

Referred By/ How did You Hear About Us:_____

Place of Employment_____ Telephone_____

Address_____

Occupation_____

Spouse's Employment (if applicable)_____

Emergency Contact:_____ (Relationship)_____

Address_____ Telephone_____

Medical Insurance: Yes_____ No_____

Policy Holder_____ DOB_____ SSN_____

Insurance Carrier_____

ID Number_____Group Number_____

Other Insurance_____

Address_____ Telephone_____

I _____ understand that I am responsible for all charges for services provided by the doctor that are not covered by my insurance. This includes "Routine" coverage.

Signed, _____ Date: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have been given the opportunity to review a copy of Madison Eye Care, LLC's Notice of Privacy Practices.

Signed, _____ Date:_____