BUGLISI EYE CARE, PLLC

Patient Information

Name_____
Date of Birth_____ Age_____ Social Security #_____ M____ F____
Address_____City_____State_____Zip_____
Phone: Home (____)_____ Cell (____)_____Work (____)_____
Which is Preferred Phone:_____
Email_____
Marital Status: Single_____ Married_____ Widowed_____ Divorced_____
Spouse Name _____
Preferred Language_____
Ethnicity: Hispanic/Latino_____ Not Hispanic/Latino_____ Unknown_____ Decline_____
Race: American Indian or Alaska Native_____ Asian_____ Black /African American_____
Native Hawaiian/Other Pacific Islander_____ White_____ Other_____ Decline_____

Complete if under 18 years or a student

Name of Father_____ Phone_____
Name of Mother _____ Phone_____

Referred by: Friend/Relative_____ Doctor_____

INSURANCE INFORMATION _ - TRICARE ONLY

Subscriber's Name_____ SS #_____ DOB_____
Relationship to Subscriber: Self_____ Spouse_____ Child_____ Other_____

Who to notify in case of emergency (nearest relative or friend)?
Name_____ Relationship_____
Address _____ Phone: (_____)_____

This information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Buglisi Eye Care or insurance company to release any information required to process my claims.

Signed (Patient or parent if minor)_____Date_____