BUGLISI EYE CARE, PLLC
Patient Information

Name _____ Date _____

Date of Birth _____ Age _____ ☐ M / ☐ F Social Security #_____

Address _____
Street City State Zip

Phone: Home (____) _____ Work (____) _____

Occupation _____ Employer _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse Name _____ Employer _____

Preferred Language: _____

Ethnicity: ____Hispanic or Latino ____Not Hispanic or Latino ____Unknown ____Decline

Race: _____American Indian or Alaska Native _____Asian _____Black or African American

_____Native Hawaiian or 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 _____
Name Name

INSURANCE INFORMATION

Insurance Company Name _____

ID # _____ Group #_____

Subscriber's Name_____ SS #_____ DOB:_____

Relationship to Subscriber: _____ Self _____ Spouse _____ Child _____Other

Name of Secondary Insurance _____

ID #_____ Group #_____

Subscriber's Name_____ SS # _____ DOB _____

Relationship to Subscriber: _____ Self _____ Spouse _____ Child _____ Other

Person Responsible for Bill:

Name _____ Relationship _____ DOB _____

Who to notify in 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 _____