CONNECTICUT CENTER for sight

CONNECTICUT CENTER FOR SIGHT, LLC
WELCOME TO OUR PRACTICE

PATIENT #_____ DATE_____

Name_____
Last First MI

Address_____

City_____State_____Zip_____

Date of Birth_____Age_____M__F__Marital Status_____

Home Phone #_____Cell #_____Work #_____

Name of spouse, parent or contact person _____

Release of medical information may be given to _____

Family Doctor_____Referred By_____

Student Full Time_____Part Time_____

Employed Full Time_____Part Time_____Retired_____Unemployed_____

NOTIFICATION REQUIRED BY THE FEDERAL GOVERNMENT

Privacy Notification and Insurance Authorization

I authorize routine release of my medical information for purposes of treatment, billing and routing health care operations. I understand that my medical information will not be released for any other purpose without my consent. I request that payment of authorized healthcare benefits be made to the providers of Connecticut Center For Sight, LLC. I authorize any medical information about me to be released to my health insurance agency any information needed to determine the benefits payable for related services. I am aware that I am responsible to understand my individual insurance benefits and that I am liable for any non-covered services.

Signature:_____Date:_____