Welcome to Our Office

Please take a moment to fill this patient information sheet. It will assist us in filing your insurance correctly for you. All information is kept completely confidential. Thank you.

How did you hear about our office? Please circle one:

Newspaper TV Doctor Referral

Family or friend Referral Yellow Pages Insurance Referral

Neighborhood Referral Other ______________________

Circle one: Dr. Mr. Mrs. Ms. Miss

Are you? Married Single Widowed

Last Name:___________________ First Name______________________

SS# _______________________________ DOB ______________________

Age: ____________ Male Female

Address: ____

City: ____________________________ ST:_______________ Zip: _________

Home Ph# ____________________ Cell Ph# ______________________

Work Ph# __________________________ext ___________

Email____________________________________@ ____________________

Employer: _________________ Occupation: __________________________

Parent or Guardian (if applicable)____________________________________

Billing Address :____

City/ST/Zip:____

Home ph# ____________________ Work ph# ______________________

Emergency Contact: ___________________ Daytime PH # ____________

If you would like for us to bill your insurance for you, please fill out the following information. Please have *ALL* insurance cards ready for the receptionist to copy. Thank you.

Vision Carrier Name :____

Primary Insured's Name:____

Insured's ID # ___________________________ Grp# ________________

Insured's SS# ____________________________ DOB: ________________________

Insured's Employer: _______________________ Relationship to patient: ____________

Medical Insurance Carrier Name :_________________________________

Primary Insured's Name:____

Insured's ID # ___________________________ Grp# ________________

Insured's SS# ____________________________ DOB: ________________________

Insured's Employer: _______________________ Relationship to patient: ____________

Do you have any other insurance? YES NO

Please read carefully and sign the following agreement.

For our patients with Insurance:
I authorize the release of any medical or other information necessary to process my claim to the insurance carriers listed above. I understand that it is my responsibility to know my insurance coverage and to obtain any referrals or authorizations necessary. I also understand that any balance not paid by the insurance company after 60 days is my responsibility. I authorize the payment of medical benefits to Dr. Gene Terrezza by my insurance carrier.

Lifetime signature:____

For our patients with Medicare:
Medicare will only pay for services that it determines to be " reasonable and necessary" under section 1862 (a) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. If there is no medical reason for your visit, or no medical diagnosis then Medicare will likely deny your claim. If Medicare denies payment, I agree to be personally and fully responsible for payment. I authorize the release of any medical or other information necessary to process my claim to the insurance carriers listed above. I understand that it is my responsibility to know my insurance coverage

and to obtain any referrals or authorizations necessary. I also understand that any balance not paid by the insurance company after 60 days is my responsibility. I authorize the payment of medical benefits to Dr. Gene Terrezza by my insurance carrier.

Lifetime signature:____

I have received a copy of Privacy Practices from Dr. Gene Terrezza, O.D., & Associates, P.A. Initial ____________