ERIC S. HUSSEY O.D., FCOVD
OPTOMETRY OFFICES, P.S.

PATIENT INFORMATION: Today's Date: _____

Name: _____

Birthdate:_____ Male____ Female _____ Circle One: Mr Mrs Ms Miss Dr Rev

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

Email Address: _____

Occupation: _____ Employer: _____

Emergency Contact Name: _____ Phone: _____

Referred By: _____ Date of Last Vision Exam: _____

Primary Care Physician: _____ Phone: _____

Does your insurance require a referral from your Primary Care Provider before seeing Dr. Hussey today? (circle one) Yes No

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT:

Name: _____

Social Security Number (for insurance billing purposes only) _____

Relationship to Patient: _____ Employer: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

VISION INSURANCE OR PLAN NAME: _____

ID or SUBSCRIBER NUMBER: _____ Group Number: _____

MEDICAL INSURANCE NAME: _____

ID or SUBSCRIBER NUMBER: _____ Group Number: _____

In order to bill your insurance, please sign BOTH lines below:

I authorize the release of any medical or other information necessary to process health insurance claims. I also request payment of government benefits either to myself or to Dr. Eric S. Hussey, dba Optometry Offices, P.S.

Signed _____ Date _____

I authorize payment of health insurance benefits to Dr. Eric S. Hussey, dba Optometry Offices, P.S. for services and/or vision hardware received.

Signed _____ Date _____