Ozer Family Vision Care
2316 Meetinghouse Road
Boothwyn, PA 19061

Patient Information

Patient Name ______________________________Email:__________________________
Address ____
Phone Number:Home______________________Work/Cell________________________
Social Security #_________________________Marital Status_____________________
Employer:_____________________ Occupation:________________________________
List Special Needs:____
Primary Language:________________________________ Race:___________________
Ethnicity:______________________
Mother's Maiden Name:___________________ Birth State: _______________________

Insurance/Billing Information

Routine VISION Coverage
Name of Primary Insured ____________________________Phone Number___________
Address ____
Employer Address____
Insurance Name ____
Insured Social Security #/Subscriber ID # _____________________Group # __________
Major MEDICAL Coverage
Name of Primary Insured ____________________________Phone Number___________
Address ____
Employer Address____
Insurance Name ____
Insured Social Security #/Subscriber ID # _____________________Group # __________

Assignment of Insurance Benefits

I, the undersigned, have insurance coverage with _______________________ and assign directly to Ozer Family Vision Care all vision and/or medical benefits, if any, otherwise payable to me for services rendered. I authorize the release of my medical records to/from Ozer Family Vision Care. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize the doctor to release all information necessary to secure payment of benefits.

Date_____________ Signed ____

HIPAA Compliance

I acknowledge Ozer Family Vision Care has presented a copy of their privacy policies.

Date_____________ Signed ____

Please provide us with your insurance card(s) so we can make copies!
Thank You
Ozer Family Vision Care