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