

Welcome to our Office

Seifert & Associates

Ph: 631-728-3132 • Fax: 631-728-0976

www.seiferteyes.com

NAME: _____
(Last) (First) (M.I.)

GENDER: M F DOB: _____ SS # _____ MARITAL STATUS: M S D W

ADDRESS: _____
(Street Address)

(City) (State) (Zip-code) (E-MAIL ADDRESS)

PHONES: _____
(Home) (Work) (Cell)

OCCUPATION: _____ EMPLOYER: _____

DATE OF LAST EYE EXAM: _____ NAME OF DR. _____

PERSON RESPONSIBLE FOR ACCT: _____ RELATIONSHIP: _____

MAJOR MEDICAL INSURANCE CO: _____ IS A REFERRAL NEEDED*? YES OR NO

NAME OF INSURED PARTY: _____ ID #: _____

INSURED'S DOB: _____ INSURED'S SS#: _____ RELATIONSHIP: _____

NAME OF PRIMARY CARE PHYSICIAN: _____
(Phone)

HOW DID YOU HEAR ABOUT OUR OFFICE?

PATIENT REFERRAL OUR WEBSITE PHONEBOOK OTHER _____

- I authorize payment of all Insurance Benefits for services rendered for this office made payable to Dr. Seifert;
- I hereby authorize Seifert & Associates to release any information required by my insurance carrier to process any claim for payment. I acknowledge that I am responsible for all non-covered charges;
- All co-pays and fees not covered by insurance are payable at time of service;
- If you belong to a Managed Care Insurance Plan and need a referral, it is your responsibility to obtain one for your appointment. If you do not have a referral, you are required to pay in full for services rendered at time of service;*
- I acknowledge that I have the option of receiving a copy of Seifert & Associates Privacy Practices featuring the new HIPAA Privacy Practices.

Signature _____ (Print Name) _____ (Date) _____