Bucci Laser Vision Institute and Angelina Theresa Bucci Eye Surgery Center
New Patient Information Form

Last Name_____ First_____ MI _____
Date of Birth____/____/____ Sex Male/Female Soc Security # _____
Address _____
City_____ State_____ Zip_____
Phone: Home ( )_____ Cell ( ) _____
E-Mail Address_____ Work ( ) _____
Occupation_____ Employer _____
Race_____ Religion_____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Name of Primary Care Physician_____ Optometrist: _____

How did you hear about us? (Check all that apply)

☐ Newspaper _____
☐ Radio _____
☐ Television _____
☐ Billboard _____
☐ Internet _____
☐ Patient/Family (Name)_____
☐ Seminar/Special Event_____
☐ Employee _____
☐ Eye Doctor/Name_____
☐ Family Doctor/PCP _____
☐ Insurance Plan _____

Complete if under 18 years or a student

Name of Father/Mother_____ Employer _____
Address _____
City_____ State_____ Zip_____
Home Phone ( )_____ Work Phone ( )_____

INSURANCE INFORMATION

Name of Policy Holder_____ DOB _____
Are you personally responsible for the payment of your fees? ☐ Yes ☐ No If not, who is?
Name_____ Relationship_____
EMERGENCY CONTACT: Who to notify in case of emergency (nearest relative or friend)?
Name_____ Relationship _____
Home Phone ( )_____ Work Phone ( )_____

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.
2. I, the undersigned, assign directly to Bucci Laser Vision Institute and Angelina Theresa Bucci Eye Surgery Center all medical payments and benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure payments of benefits. I authorize the use of the signature on all insurance submissions.
3. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed (Patient or parent if minor)_____ **Date**_____