Patient Information:

Name: ____________________________Date: __________Gender: Male/Female Birth Date_________

Social Security #_____________ Primary Care Doctor: ____________________

Employment Status: __________ Employer: _____________ Occupation: _______________

Insurance Information
PLEASE HAVE INSURANCE CARDS READY FOR US TO MAKE A COPY

Primary Medical: ______________________policy#_________________________Group#_____________

Secondary Medical: ____________________policy# ________________________Group#_____________

Vision Plan: _________________________

Communication Pref: email/postal/telephone Email Address: ______________________________

Marital Status: Single/ Married/ Divorced

Preferred Language: English/Spanish

Race: American Indian/Alaskan, Asian, Black/African American, Hispanic/Latino, Pacific Island/Hawaiian, White

Ethnicity: Hispanic/Latino, Pacific Island/Hawaiian, Not Hispanic

Responsible Party Information:

Person Responsible for this account: ____ Birth Date:
SS # __________________ Relationship to Pt:___________________
Address (if different than patients) ____

Financial Authorization:

_________I hereby give consent to Francis L Pinard OD PC or any doctors at this location to provide eye care services to myself and/or person for whom I am legally responsible. I understand that I am ultimately responsible, regardless of my insurance status, for any charges incurred by me or any party for whom I am legally responsible.

Lifetime Insurance Signature:

_________I authorize use of this signature for all my insurance submissions. I authorize payment of benefits directly to Francis L Pinard OD PC. I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of the original.

Medicare Waiver

_______I understand that Medicare does not pay for service code 92015 (Refraction). I will be responsible for this $45.00 charge if not covered by a supplemental insurance policy.

Acknowledgement of Privacy Policy

_______I acknowledge that I have viewed and been offered a copy of the privacy policy (HIPPA) for Francis L Pinard, OD PC

Signature: ____Date____________

Francis L. Pinard, OD., PC & Associates
Newport Optical
Green Mountain Eye Care

Designation of Personal Representative

Patient Name: ___________________________________Date of Birth: ___________________

I, ____, give the following individual(s)
(Patient or Guardian)
access to my protected health information.

________________________________Emergency Contact: Yes/No Phone:______________
(Name)
Relationship to patient: __________________________

________________________________Emergency Contact: Yes/No Phone: ______________
(Name)
Relationship to patient: ___________________________

________________________________Emergency Contact: Yes/No Phone: _______________
(Name)
Relationship to patient: _____________________________

I understand that by granting the above-named individuals access to my medical records, I allow my doctor and his staff to speak with them regarding my diagnosis, treatment and overall care. They will have access to my exam notes as well as any supplementary testing, photographs, referral notes and financial information.

Signature: _______________________________________Date: ________________

**** Designation of Personal Representative is valid until revoked by patient or guardian