LAKEVILLE EYE ASSOCIATES, LLC

Name:____

Address:____

City/Town:_________________________State:_____Zip:__________---_______

Telephone(home):_________________________(work):_______________________

Fax:_______________Cell:__________________Email:_______________________

Date of Birth:____________________Social Security#:_______________________

Occupation:____

Employer:____

Primary Physician:___________________________Referred By:_________________

Parents Name and Address (for out-of-town students):

____

I authorize the release to my insurance carrier of all information necessary for processing claims. I authorize payment of medical benefits directly to Lakeville Eye Associates. I understand that I will be responsible for payment in full if I have not complied with the requirements of the carrier or if the services are not covered. I authorize Dr. Kirber and Dr. Tantri to release information to my primary physician, referring doctor(s) and consultant(s) involved in my care. I acknowledge that a copy of Lakeville Eye Associates privacy policy that outlines all of the ways my information can legally be used has been made available to me. I give permission to be reminded of appointments by post card and to be called by name in the office.

You may speak with:____

____regarding my health care.

Signature:____Date:_____________

Relationship to Patient:____