DRAGA EYE CARE & SURGERY ASSOCIATES
208-01 NORTHERN BLVD 2ND FL.
BAYSIDE, NEW YORK 11361

PATIENT INFORMATION
(PLEASE FILL OUT THE FOLLOWING)

NAME:_____ HOME PHONE: ( )_____-_____

ADDRESS:_____ WORK PHONE: ( )_____-_____

CITY/STATE_____/_____ZIP_____ CELL PHONE: ( )_____-_____

EMPLOYER:_____ DATE OF BIRTH: _____/_____/_____
MONTH DAY YEAR

REFERRED BY:_____ SS#: _____-_____-____

PRIMARY DOCTOR:_____ MARITAL STATUS:_____SEX:_____

ADDRESS:_____ DOCTOR'S NUMBER: ( )_____-_____

EMERGENCY CONTACT :_____ PHONE( ) _____-_____

PHARMACY INFORMATION

NAME :_____ PHARMACY PHONE NUMBER: ( )_____-_____

ADDRESS:_____

INSURANCE INFORMATION

RESPONSIBLE PARTY (SELF) OR OTHER: _____RELATIONSHIP:_____

PRIMARY INSURANCE:_____ ID NUMBER:_____

SECONDARY INSURANCE:_____ ID NUMBER:_____

NAME OF COLLEGE (IF PATIENT IS A STUDENT)_____

INSURED DATE OF BIRTH:_____/_____/_____

PRIVATE INSURANCE/SELF PAY::
I understand that I am individually responsible for the full payment of the fee for services rendered to me by this office. I understand that all medical care provided to me or my child is on a "fee for service" basis and that I have been duly informed of the fees for services provided by this office.
MEDICARE:
I request that payment of authorized Medicare benefits be made directly to Dr. Draga on my behalf for any medical services furnished to me. I authorize the release of any medical information about me; to any Healthcare care Financing Administration and its agent, needed to determine these benefits of the benefits payable for related services.
MANAGED CARE PLANS: I hereby assign directly to Dr. Draga all medical benefits. If any, otherwise payable to me for me for services rendered. I understand that I am fully responsible for all charges not paid by my insurance. I hereby authorize the use of this signature on all insurance submissions

PATIENT / AUTHORIZED SIGNATURE:_____ DATE:_____