OPTX
rhode island

giulio diamante, md
& associates
exceptional eyecare

giulio diamante, md
board certified

BROWN
Alpert Medical School
clinical assistant professor of ophthalmology

Personal Information

Name: ______________________________ Date ______________

Address: ____

City: ____________________ State: __________ Zip Code: ____________

Date of Birth: ________________ Age: __________ Sex: ❒ Male ❒ Female

Phone: home (____) ____________ Social Security #: ____________________

cell (____) ____________

E-mail address: ____

Occupation: ____________________ Employer or School: ____________________

Primary Care Physician: ____________________ Pharmacy: ____________________

Marital Status: ❒ single ❒ married ❒ domestic partnership ❒ separated ❒ widowed ❒ divorced

Spouse Name: ____________________ Employer: ____________________

Whom were you referred by? ❒ friend/relative ____________ ❒ doctor ____________

❒ internet ❒ insurance company ❒ other ____________

Is this a work-related visit? ❒ yes ❒ no

Emergency contact:

name: ____________________ relationship: ____________________

phone number: ____________________

• Complete if under 18 years of age or a student

Name of father: ____________________ **Email:** ____________

Address: ____________________ **Phone (cell):** ____________

City: ____________ **State:** ________ **Zip:** ________ **Phone (home):**____________

Occupation :____________________ **Employer:** ____________

SSN: ____________________

Name of mother: ____________________ **Email:** ____________

Address: ____________________ **Phone (cell):** ____________

City: ____________ **State:** ________ **Zip:** ________ **Phone (home):**____________

Occupation :____________________ **Employer:** ____________

SSN: ____________________

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Insurance Information

Primary insurance company name: ____________________

Subscriber's name: ____________________ Subscriber DOB: ____/____/______

Relationship to insured: ____________________ Subscriber SSN: ____/____/______

ID number on insurance card: ____________________ Group number: ____________

Secondary insurance company name: ____________________

Subscriber's name: ____________________ Subscriber DOB: ____/____/______

Relationship to insured: ____________________ Subscriber SSN: ____/____/______

ID number on insurance card: ____________________ Group number: ____________

Tertiary insurance company name: ____________________

Subscriber's name: ____________________ Subscriber DOB: ____/____/______

Relationship to insured: ____________________ Subscriber SSN: ____/____/______

ID number on insurance card: ____________________ Group number: ____________

- **If you have a vision plan, please complete the following:**

Plan name (choose one): ❒ Vision Service Plan (VSP) ❒ Eyemed ❒ Davis Vision
❒ Other: ____________________

Subscriber's name: ____________________ DOB: ____________

SSN: ____________________

Worker's Compensation

Is your visit related to worker's compensation? ❒ yes ❒ no --if yes, please complete the following:

Company name: ____________________

Address: ____________________

City: ____________________ **State:** ____________ **Zip Code:** ____________

Contact person: ____________________ **Claim number:** ____________

Please read and sign below

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 allowance 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 by your insurance company.**

2. In order to control the high cost of billing, we request that your copays and charges for office visits be paid at the conclusion of each visit. You will be charged a billing fee for any mailed balance which was due at your visit.

3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any service furnished to me. I authorize any holder of my medical information to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

4. HMO type plans require that the patient contact their primary care physician for a referral or prior authorization for certain services. It is the patient's responsibility to follow plan guidelines. **If you do not obain the correct referral/authorization prior to being seen by Dr. Diamante and Associates, you may have to assume financial responsibility for these services.**

5. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize Dr. Diamante and Associates to release all information necessary to secure payment.

Signed (patient or parent if minor): ____________________

Date: _____/______/_________