Fontana Eyecare Associates

Dr. Frank D. Fontana **Dr. Jeffrey A. Kempf**

WELCOME TO OUR OFFICE

Mr., Mrs., Ms., Miss, Dr., Other _____ Nickname _____ Date _____

Name (First) _____ (Middle) _____ (Last) _____

Address _____ City _____ State _____ Zip_____

Phone (home) _____ (work) _____ (cell) _____

e-mail _____ How would you prefer to be contacted? home / work /cell / text / e-mail

Birth Date _____ Age _____ Hobbies _____

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse _____ (Our Patient? Yes/No) Who recommended us?_____

If child: Parent or Guardian _____

Educational Level Completed: 7 8 9 10 11 12 College: 1 2 3 4 Graduate School _____

Occupation _____ Employer _____

Social Security # _____ Medicare # _____

I have received a copy of Fontana Eyecare Associates Notice of Privacy Practices _____ _____
Patient initials Date

I hereby authorize Fontana Eyecare Associates to use and disclose my medical and financial information with the person(s) identified below. It is at my request, that the specific information that may be used and disclosed to this person(s), includes any and all of my personal health information in the records of the Practice that pertain to me.

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

This Authorization shall expire upon the earlier of 1) a written revocation of this Authorization; 2) upon my termination of all services with the Practice; or 3) until the date of _____.

We require payment when services are rendered. If you are using any kind of insurance, it is your responsibility to provide us with your benefit information prior to your examination. The filing of a claim DOES NOT GUARANTEE PAYMENT from your insurance company. Having more than one insurer DOES NOT mean your services are covered 100%.

Will you be paying for today's services by: Cash, Check, Mastercard, Visa, Discover, Care Credit

Signature _____ Date _____

PLEASE TURN PAGE OVER