ASHVANI K. GULATI, MD

BUFFALO EYE CENTER

FRANCESCO J. BARBAROSSA, OD

NEW PATIENT INFORMATION

Last Name: _____ First Name: _____ MI:_____ Sex: M F

Address: _____ City:_____ State: _____ Zip:_____

Phone: _____ Cell/Work Phone:_____ DOB:_____ Age:_____

Email Address: _____ SS#:_____

Name of Spouse (parent/guardian if minor) _____ Phone:_____

Emergency Contact: _____ Phone:_____ Relationship:_____

Primary Doctor: _____ Phone: _____

Address: _____ City:_____ State:_____ Zip:_____

Primary Pharmacy: _____ Phone: _____

Address: _____ City:_____ State:____ Zip:_____

Secondary Pharmacy: _____ Phone: _____

Address: _____ City:_____ State:_____ Zip:_____

INSURANCE/ EMPLOYMENT INFORMATION

Primary Insurance: _____ ID#_____

Name of Policyholder: _____ DOB:_____ Relation to patient: _____

Secondary Insurance: _____ ID#_____

Name of Policyholder: _____ DOB: _____ Relation to patient: _____

Employer Name: _____ Phone: _____ ext_____

Employer Address: _____ Occupation:_____

I authorize the doctor(s) to bill my insurance company and to provide them with any necessary medical information needed to bill this claim. I certify that the information I have provided with regard to my insurance is correct. I understand that I am responsible for my co-payments, co-insurance or deductibles and that payment is due at the time of my visit.

Patient Signature:_____ Date:_____