

**Madison Eye Care, LLC**

Maria I. Diaz O.D.

1347 Boston Post Road Suite 101  
Madison, CT 06443

Eileen Bush O.D.

Telephone:203-245-8567  
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**WELCOME TO OUR PRACTICE!**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ SSN: \_\_\_\_\_

Address \_\_\_\_\_

(Street) (City) (State) (Zip)

Marital Status: \_\_\_\_\_ If married, spouse's name \_\_\_\_\_

Home Telephone \_\_\_\_\_ Other Phone (cell/work) \_\_\_\_\_

Referred By/ How did You Hear About Us: \_\_\_\_\_

Place of Employment \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Employment (if applicable) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ (Relationship) \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

**Medical Insurance: Yes \_\_\_\_\_ No \_\_\_\_\_**

**Policy Holder** \_\_\_\_\_ **DOB** \_\_\_\_\_ **SSN** \_\_\_\_\_

Insurance Carrier \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Other Insurance \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

**I \_\_\_\_\_ understand that I am responsible for all charges for services provided by the doctor that are not covered by my insurance. This includes "Routine" coverage.**

Signed, \_\_\_\_\_ Date: \_\_\_\_\_

**RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM**

I, \_\_\_\_\_, have been given the opportunity to review a copy of Madison Eye Care, LLC's Notice of Privacy Practices.

Signed, \_\_\_\_\_ Date: \_\_\_\_\_