Francis L. Pinard, OD., PC & Associates
Newport Optical
Green Mountain Eye Care

Patient Information:

Name: _____Date: _____Gender: Male/Female Birth Date_____

Mailing Address: _____

Email Address: _____ Home #_____Cell#_____

Social Security #_____ Primary Care Doctor: _____

Employment Status: _____ Employer: _____ Occupation: _____

Insurance Information
PLEASE HAVE INSURANCE CARDS READY FOR US TO MAKE A COPY

Primary Medical: _____policy# _____Group#_____

Secondary Medical: _____policy# _____Group#_____

Vision Plan: _____

Marital Status: Single/ Married/ Divorced/ Widowed

Preferred Language: English/ Spanish / French

Race: American Indian/Alaskan, Asian, Black/African American, Hispanic/Latino, Pacific Island/Hawaiian, White

Ethnicity: Hispanic/Latino, Pacific Island/Hawaiian, Not Hispanic

Responsible Party Information:

Person Responsible for this account: _____ Birth Date:
SS # _____ Relationship to Pt :_____
Address (if different than patients) _____

Financial Authorization:

_____I hereby give consent to Francis L Pinard OD PC or any doctors at this location to provide eye care services to myself and/or person for whom I am legally responsible. I understand that I am ultimately responsible, regardless of my insurance status, for any charges incurred by me or any party for whom I am legally responsible.

Lifetime Insurance Signature:

_____I authorize use of this signature for all my insurance submissions. I authorize payment of benefits directly to Francis L Pinard OD PC. I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of the original.

Medicare Waiver

_____I understand that Medicare does not pay for service code 92015 (Refraction). I will be responsible for this $45.00 charge if not covered by a supplemental insurance policy.

Acknowledgement of Privacy Policy

_____I acknowledge that I have viewed and been offered a copy of the privacy policy (HIPPA) for Francis L Pinard, OD PC (Policy is available at the front desk)

Designation of Personal Representative

Patient Name: _____Date of Birth: _____

I, _____, give the following

individual(s) access to my protected health information.

_____Emergency Contact: Yes/No Phone:_____
(Name)
Relationship to patient: _____

_____Emergency Contact: Yes/No Phone: _____
(Name)
Relationship to patient: _____

_____Emergency Contact: Yes/No Phone: _____
(Name)
Relationship to patient: _____

I understand that by granting the above-named individuals access to my medical records, I allow my doctor and his staff to speak with them regarding my diagnosis, treatment and overall care. They will have access to my exam notes as well as any supplementary testing, photographs, referral notes and financial information.

Signature: _____Date: _____

**** Designation of Personal Representative is valid until revoked by patient or guardian