Welcome To Our Office!

Please complete the following form as thoroughly as possible. The information in this confidential case history form is critical to the evaluation of your vision and health.

BERGAMO VISION

Patient Information

Last: _____

First: _____MI: _____

Street: _____

City: _____State: _____

Zip Code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

How do you prefer to be contacted?

(Indicate #1 and #2 preference):

Home #____Work #____Cell #____Text____Email_____

Date of Birth: _____Age: _____

Sex: M F

Employer (or School): _____

Occupation (or Grade): _____

Spouse (or Parent's Name): _____

*I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment above.

Signed: _____

Printed Name: _____

*I authorize payment of medical benefits to Bergamo Vision, PC or supplier for services rendered.

Signed: _____

Printed Name: _____

Insurance Information

Vision Insurance:_____

Subscriber Name:_____

Subscriber SSN/ID#:_____

Subscriber Birth Date:_____

Primary Medical Insurance:_____

Subscriber Name:_____

Subscriber SSN/ID #:_____

Subscriber Birth Date:_____

Secondary Medical Insurance:_____

Subscriber Name:_____

Subscriber SSN/ID#:_____

Subscriber Birth Date:_____

Name of Family Physician: _____

Office: _____

Address:_____

Phone:_____

Do you participate in a flex spending account?

☐ Yes ☐ No

If not referred, how did you choose our office?

☐ Friend or Relative
☐ Other Doctor
☐ Insurance List
☐ Saw Sign/Building
☐ Website
☐ Online Search. If yes, where did you find us?

_____

☐ Other: _____