



3400 Technology Drive, Suite 107 • East Setauket, NY 11733
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Vincent P. Basilice, MD, PC, Medical Director

Michael S. Conners, M.D., Ph.D. • Alexander J. Llinas, M.D., Ph.D. • Joseph Crapotta, M.D. • Alex Schaffer, O.D.

Laser Vision Checklist

Please complete the following:

1. Name: _____
2. What was the month / year of your last eye exam? _____
3. Have you noticed a change in your vision? _____
4. What are you presently wearing? ___ Glasses ___ Soft or Hard Contact lenses ___ Both
5. Are you : ___ Nearsighted ___ Farsighted
6. Do you have astigmatism? ___ Yes ___ No
7. Are you aware that we now offer Lasik Vision Correction to correct nearsightedness, farsightedness and astigmatism? ___ Yes ___ No
8. Would you like to discuss Laser Vision Correction with our technical staff? ___ Yes ___ No
9. Would you like a Lasik information package and Vision Access payment package to take home with you? ___ Yes ___ No

Thank you. Please return this form to our Front Desk.

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Last Name _____ First _____ Date of birth _____ Gender: M F

SS # _____ [] Single [] Married [] Widowed **E-MAIL** _____

Address _____ City _____ State _____ ZIP _____

Hm Ph # _____ Work Ph # _____ Cell # _____

Occupation _____ Employer _____

Emergency Contact _____ Ph # _____

I am a [] **New Patient** [] **Existing Patient**

How did you hear about us?

[] **Times Beacon** [] **Movie Theater** [] **Diner** [] **Other (Please specify)** _____

Primary Care Dr: _____ Address/Town _____

Referring Dr: _____ Address/Town _____

Pharmacy name and number(s): _____ Address/Town _____

Other treating Dr(s): _____ Address/Town _____

Primary Insurance Information

Insurance Co Name _____ Name on Card _____

ID# (s) _____ Relationship [] Self [] Spouse [] Child [] Other

Policy Holders Name _____ DOB _____ SS# _____

Policy Holders Employer _____ Holders ph # _____ Copay \$ _____

Secondary Insurance – 2nd insurance (If Applicable)

Insurance Co Name _____ Name on Card _____

ID# (s) _____ Relationship [] Self [] Spouse [] Child [] Other

Policy Holders Name _____ DOB _____ SS# _____

Policy Holders Employer _____ Holders ph # _____ Copay \$ _____

Tertiary Insurance – 3rd insurance (If Applicable)

Insurance Co Name _____ Name on Card _____

ID# (s) _____ Relationship [] Self [] Spouse [] Child [] Other

Policy Holders Name _____ DOB _____ SS# _____

Policy Holders Employer _____ Holders ph # _____ Copay \$ _____

I verify that the above information is accurate. I understand that The Ophthalmic Center has a **no show policy** if I do not show up for an appointment, and I have not given 24 hour notice of cancelation, there will be a **\$25 fee that I am responsible to pay.**

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Assignment of Benefits

I understand that by using my insurance, in this office, that it is my responsibility to do the following:

- Obtain a referral when necessary. _____ (initial)
- Co-pays and existing Balances will be collected prior to your exam. If you do not have your co-pay or existing balance, you will be asked to reschedule your appointment. _____(initial)
- Pay any expenses that are not covered by my insurance. _____ (initial)

I authorize the release of the information as necessary to process my insurance claim. _____ (initial)

I authorize my insurance company and or Medicare to pay this office for services provided to me. _____ (initial)

I understand that the staff at The Ophthalmic Center will make every effort to inform me of charges that will not be covered by my insurance.

I understand that The Ophthalmic Center will bill my insurance company on my behalf. I understand that if there are any additional fees that my insurance does not pay for, I am responsible for those fees. I understand that I will be responsible for any legal fees if my account is not paid. I understand that any additional collection fees will also be my responsibility.

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Receipt of Notice of Privacy Practices Written Acknowledgement

I, _____ (initial) have received or viewed a posted copy of The Ophthalmic Center’s notice of Privacy Practices.

Patient /Authorized Representative Signature _____

Print Name _____ Date _____