ASHVANI K. GULATI, MD **BUFFALO EYE CENTER** FRANCESCO BARBAROSSA, OD

Patient Name: ______________________ **DOB:** ______________ **SEX:**

Address: ______________________ **SS#:** ______________ **M F**

______________________ **Phone #:** ______________

Email: ______________________ **Cell#:** ______________

If under 21 Name of Father / Mother: ______________________

Marital Status: **S M W D** **Spouse:** ______________________

Referred by: ______________________

Primary Care Doctor: ______________________

Primary Pharmacy:

Name: ______________________ **Phone#:** ______________

Address: ______________________

Secondary Pharmacy:

Name: ______________________ **Phone#:** ______________

Address: ______________________

Employer: ______________________ **Occupation:** ______________

Employer Addresss: ______________________ **Work #:** ______________

Primary Insurance: ______________________

Secondary Insurance: ______________________

I authorize the doctors to bill my insurance company and to provide them with any pertinent medical information. I understand I am responsible for any payment not covered by my insurance company.

______________________ ______________

Patients Signature Date