Richard B. Krzyzak, O.D. **Michael S. Krzyzak, O.D.** **Thomas J. Wells, O.D.** **Kelly A. Chajka, O.D.**
4871 West Taft Road, Liverpool, New York 13088

Welcome to our Office

Date: _____________ **Home Phone:** ________________ **Cell Phone:** _________________ **Text: Yes / No**

PATIENT NAME:______________________ __________________________ ___________
Last Name First Name Initial

Address: ______________________________**City**_____________________**State**______ **Zip** _________

Birth date______________ **Sex** ☐ **Male** ☐ **Female**

Race*:* **White □ Hispanic □ African American □ Other□** **Communication Preferred: Email □ Postal □ Telephone □**

Social Security #:____________________________ **Email Address:**_____________________________

Single ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced** ☐

Patient Employed by: ____ **Business Phone:** _____________________________

VISION INSURANCE: Do you have VSP Insurance? _____ **YES** _____ **NO**

VSP MEMBERS NAME:___________________________ **VSP MEMBERS ID #**_________________________

Relationship to patient:____________________________

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Do you have any additional Vision Plan? _____ **YES** _____ **NO**

VISION PLAN NAME: _____________________________________ **ID#:**________________________________

VISION PLAN MEMBERS NAME: ____________________________ **Members Date of Birth:**________________

MEMBERS EMPLOYER NAME:______________________________

MEDICAL INSURANCE: Primary Insurance Name: ________________________ **ID#:**________________________

Medical Insurance MEMBERS NAME:__________________________________

Insurance Member Employed by: __________________________________ **Relationship to patient:**__________________

Insured's Birthdate: _______________ **Is address the same? If not address:**_____________________________________

City _______________________ **State** _______ **Zip** _____________ **Phone Number** ________________________

Secondary Medical Insurance Name: __________________________ **ID#:**________________________________

Secondary Medical Insurance MEMBERS NAME: ________________________

BILLING INFORMATION: We will be glad to bill your Insurance if we participate with your insurance program. WE ACCEPT MEDICARE ASSIGNMENT

I acknowledge that I have read and/or received a copy of the Notice of Privacy Practice. I give authorization to Krzyzak Eyecare to release any information including the diagnosis and the records of any treatment or examination rendered to me to my insurance company. I authorize and request my insurance company to make payment directly to Krzyzak Eyecare.

____ ______________________________
AUTHORIZED SIGNATURE OF SUBSCRIBER **DATE**