OFFICE OF RICHARD J. MANGANIELLO, M.D.

LAST NAME: ____________________________ FIRST NAME: ________________________ MID INITIAL: _____

STREET ADDRESS: ____ TOWN: ___________________________

STATE: ___________ ZIP CODE: ________________ EMAIL ADDRESS: __________________________________
(PLEASE WRITE LEGIBLY)

☐ MALE ☐ FEMALE SOCIAL SECURITY # ______ - _____ - ______ DATE OF BIRTH: _____/ _____ / _____

CELL: (______)________________ HOME TEL: (______)________________ WORK TEL: (______)______________ EXT. ______

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED ☐ PARTNERSHIP

1) **LANGUAGE**: ☐ **ENGLISH** ☐ **SPANISH** ☐ **OTHER**: ___________________________

2) **ETHNICITY**: ☐ **HISPANIC OR LATINO** ☐ **NOT HISPANIC OR LATINO** ☐ **REFUSED TO ANSWER**

3) **RACE**: ☐ **AMERICAN INDIAN** ☐ **BLACK OR AFRICAN AMERICAN** ☐ **HAWAIIAN OR PACIFIC ISLAND**
☐ **ASIAN** ☐ **WHITE** ☐ **UNKNOWN** ☐ **REFUSED TO ANSWER**

EMPLOYER: ____ OCCUPATION: __________________________________

EMPLOYER ADDRESS ____

EMERGENCY CONTACT / SECONDARY CONTACT PERSON:

NAME ____________________________________ PHONE (______)_______________ RELATIONSHIP __________________

PRIMARY CARE DOCTOR: ____
(FULL NAME) (ADDRESS/TOWN)

PHARMACY- RETAIL: ____
(NAME) (ADDRESS/TOWN)

PHARMACY- MAIL ORDER: ______________________________ REFERRING PHYSICIAN: ___________________________
(NAME)

INSURANCE INFORMATION

1) PRIMARY INSURANCE**:** _____________________________________ ID# ___________________________________

SUBSCRIBER'S NAME: ___________________________________ SUBSCRIBER'S D.O.B.: _____ / _____ / _______

RELATIONSHIP TO PATIENT: _____SELF _____SPOUSE _____PARENT OTHER: _________________________________

2) SECONDARY INSURANCE**:** ___________________________________ ID# ___________________________________

SUBSCRIBER'S NAME: ___________________________________ SUBSCRIBER'S D.O.B.: _____ / _____ / _______

RELATIONSHIP TO PATIENT: _____SELF _____SPOUSE _____PARENT OTHER: _________________________________

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:

___ DECREASED DISTANCE VISION ___ CHANGE IN FLOATERS ___ DIMMING OF VISION

___ DECREASED NEAR VISION ___ FLASHES OF LIGHT ___ WORSENING NIGHT VISION

___ ITCHING, REDNESS, OR TEARING ___ DOUBLE VISION ___ SEEING HALOS / GLARE ISSUES

___ **OTHER (please explain)**: ____

HOW DID YOU HEAR ABOUT US? ☐ FAMILY ☐ FRIEND ☐ HOSPITAL ☐ WEBSITE
☐ YELLOW PAGES ☐ INTERNET ☐ INSURANCE DIRECTORY ☐ PHYSICIAN ☐ OTHER: ______________________

SIGNATURE AND FINANCIAL AUTHORIZATION: I certify that insurance information I have provided is accurate. Insurance submission is provided as a courtesy to me and I am responsible to provide correct insurance information and obtain any required referrals. I am responsible for all co-payments, deductibles, refraction fees, & balances not covered by my health insurance. **I agree to pay any co-payments, refraction fees, & deductibles at the time of service.** In the event of default, I understand a finance charge may be added to my outstanding account after 30 days. The minimum monthly finance charge is $15.00 or 18% per annum (whichever is greater). Unless I have made previous arrangements, any outstanding balance will be sent to collections after 3 statements. I agree to pay all collections costs & legal fees associated with collecting the debt and a $35.00 fee for any returned or NSF check.

CEPS 12-09-19

SIGNATURE: _______________________________________ DATE: ___________________________

NAME (PRINT): ______________________________ RELATIONSHIP TO PATIENT: ____________________