Dr. Susan F. Tomasino, OD
192 Worcester Road, Natick MA 01760

Patient Registration Form

Name:_____ SS#_____
Last First MI

Address:_____
Street City State ZIP

Home Phone: (___)_____ Cell: (___)_____ DOB: ___/____/_____ Age _____

Email Address:_____ Gender: □ Male □ Female

May We Contact You Via: □ Email □ Text Message

Occupation: _____ How Did You Find Us? _____

Employer: _____
Name City State Zip Phone

Primary Physician:_____
Name City Phone

Referring Physician (If applicable): _____

Person Responsible For Payment (if not above): _____
Name Relationship

Address:_____
Street City State Zip Phone

Please Bring All Insurance Cards With You
ALL PAYMENTS & CO-PAYMENTS ARE EXPECTED AT TIME OF SERVICE

Insurance Name:_____

Insurance Name:_____

Medicare Insurance
I request that payments of authorized Medicare benefits be made either to me or on my behalf to Dr. Tomasino, OD for any services furnished to me by that/those physicians. I authorize any holder of medical information about me to be released to HCFA and its agents to determine these benefits or the benefits payable for related service.

All other insurances and Private Pay:
I authorize the release of any medical information necessary to process insurance claims. I also authorize payment of medical benefits directly to my physician. If needed a consent or a referral from my Primary Care Physician, and have not obtained one, I understand I am financially responsible for charges incurred. I understand that if my account is delinquent and is turned over to a collections agency, I will be responsible for all collections costs.

Signature: _____ Date: _____/____/_____