Name:
DOB:
Chart:
Age:
Date:

Charles F. Lanzillo, Jr., M.D.
Prior L. Parker, M.D.
Nora Ann M. Lucchi, O.D.

THAMES EYE GROUP, P.C.

Your Eyes Are Our Specialty

200 Sandy Hollow Road - Mystic, CT (860) 536-4916
17 Wells Street - Westerly, RI (401) 596-0339

PLEASE COMPLETE IN FULL

PATIENT'S LAST NAME	FIRST NAME	MIDDLE INITIAL	PHONE 1
STREET ADDRESS			PHONE 2
CITY	STATE	ZIP	PHONE 3
DATE OF BIRTH	SOCIAL SECURITY NUMBER	SPECIAL NEEDS	GENDER
PREFERRED LANGUAGE ☐ English ☐ Spanish ☐ Other ☐ Patient Refusal	RACE ☐ Native American ☐ Asian ☐ African American ☐ Caucasian ☐ Patient Refusal	ETHNICITY ☐ Hispanic ☐ Non-Hispanic ☐ Patient Refusal	MARITAL STATUS ☐ M ☐ S ☐ D ☐ W ☐ O
EMPLOYER	ADDRESS		IS THIS WORK RELATED
SPOUSE/PARENT NAME	SPOUSE/PARENT EMPLOYER		SPOUSE/PARENT DOB
PRIMARY CARE PHYSICIAN STATE	PHARMACY USED CITY		

PLEASE PRESENT INSURANCE CARDS AND PHOTO ID TO THE RECEPTIONIST

CONSENT TO TREAT and ASSIGNMENT OF BENEFITS

I hereby authorize the providers of Thames Eye Group, P.C. to examine me and to release my records to anyone that I designate. I further authorize treatment deemed necessary based on the health care professional's findings.

I hereby authorize Thames Eye Group, P.C. to apply for benefits on my behalf for covered services rendered. I request payment from my insurance plan be made directly to Thames Eye Group, P.C. I authorize the release of any necessary information, including medical information for this or any related claim to the insurance carrier.

Signature of Patient or Guardian