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Doctors of Optometry
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Port Matilda, PA 16870
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PATIENT	**SPOUSE/GUARDIAN**
NAME: ________________________	NAME: _______________________
SSN: __________________________	SSN: _________________________
DATE OF BIRTH: _______________	DATE OF BIRTH: ______________

PRIMARY OR MEDICARE NUMBER: _____________________________________

SECONDARY NUMBER: ____

I request that payment of authorized Primary Insurance benefits be made either to me or on my behalf to **Tracy C. Sepich, O.D., M.S./Christine A. Zlupko, O.D.,** for any service furnished me by the physician or supplier. I authorize any holder of medical information about me to release to ___________________________________ and its agents any information needed to determine these benefits payable for related services.

____ _______________________
BENEFICIARY SIGNATURE DATE

SECONDARY INSURANCE
I request that payment of authorized Secondary Insurance benefits be made either to me or on my behalf to **Tracy C Sepich, O.D., M.S./Christine A. Zlupko, O.D.,** for any services furnished me by the physician or supplier. I authorize any holder of medical information about me to release to ________________________any information needed to determine these benefits or the benefits payable for related services.

_______________________________________ ________________________
BENEFICIARY SIGNATURE DATE