

**Restore Eye Care, P.C.**

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*Doctor of Optometry*

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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