KALAMAZOO OPHTHALMOLOGY, P.C.

3412 West Centre Street
Portage, Michigan 49024
(269) 329-5860 1-800-537-3327

Patient #: _____ Doctor: _____ Date: _____

Patient's Name: _____ (First / M / Last) Date of Birth: _____

Patient Sex: M F Patient SSN: _____ Marital Status: S M W D

Patient Address: _____ Apt. # _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Patient Occupation: _____ Patient Employer: _____

Spouse: _____ Preferred Language: _____

Race: _____ Ethnicity: _____ Email Address: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Home Phone #: _____ Work Phone #: _____

If patient is a minor, person responsible for account:

Name: _____ Relationship: _____ D.O.B.: _____ SSN.: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Employer: _____ Work Phone #: _____

Insurance Information

PRIMARY INSURANCE:

Insurance Co. Name: _____ Subscriber Name: _____

Subscriber SSN: _____ Subscriber D.O.B: _____

Policy/Plan/Group#: _____ Employer: _____

SECONDARY INSURANCE:

Insurance Co. Name: _____ Subscriber Name: _____

Subscriber SSN: _____ Subscriber D.O.B: _____

Policy/Plan/Group#: _____ Employer: _____

OTHER INSURANCE:

Insurance Co. Name: _____ Subscriber Name: _____

Subscriber SSN: _____ Subscriber D.O.B: _____

Policy/Plan/Group#: _____ Employer: _____

PRIMARY PHYSICIAN: _____ Referring Physician: _____

Is your visit work related? Y N Date Accident Occurred: _____

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ASSIGNMENT AND RELEASE

I, the undersigned, hereby authorize the release of any surgical and/or medical information necessary for the processing of insurance benefits payable to myself or to Kalamazoo Ophthalmology P.C. including medical and/or major medical benefits. I am financially responsible for services not covered by this assignment. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signature of patient or guardian Date

I hereby give my permission to Kalamazoo Ophthalmology P.C. and Dr. _____ to administer treatment/eye exam and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my condition.

Signature of patient or guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Kalamazoo Ophthalmology P.C. for any services furnished me by said provider. I authorize any holder of surgical and/or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown.

Signature of patient or guardian Date