KEAMY EYE AND LASER CENTER
PATIENT CONFIDENTIAL INFORMATION

Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone:_____

Work Phone:_____ Cell Phone:_____

E-Mail Address_____ Sex: Male Female

SSN:_____ Occupation:_____

Date of Last Eye Exam:_____ Doctor's Name:_____

Notify in case of emergency:_____ Phone Number_____

How did you hear about our office?_____

<u>Primary Physician Information</u>

Primary Physician: _____Primary Physician Number: _____

<u>Insurance Information</u>

Name of insurance: _____

Insurance ID number: _____ Group number: _____

Policyholder name: _____Relationship to policyholder: _____

Policy holder SSN: _____ Policyholder Date of Birth_____

Policyholder Employer: _____Work Number:_____

Home Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____

Second Insurance: _____

Insurance ID number: _____ Group number_____

Release of information: I hereby authorize Keamy Eye and Laser Centre to furnish and disclose all known facts concerning my care to my insurance company and other physicians upon my request.

Assignment of benefits: I hereby authorize all insurance companies to make payments directly to Keamy Eye and Laser Centre or any insurance benefits for professional services rendered. I understand that I am responsible for any charges not paid by my insurance company. If my insurance company requires written referral and I do not have a referral for my visit, I understand I am responsible for payment of the services provided.

Signature: _____ Date: _____