KALUZNE VISION CARE

PATIENT INFORMATION FORM

First Name _____ MI _____ Last Name _____

Date of Birth _____ Social Security Number _____

Gender ☐ Male ☐ Female Marital Status _____ Race _____

Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email Address _____

How would you like to be contacted? ☐ Cell Phone ☐ Home Phone ☐ Text ☐ Email ☐ Work Phone

Employer/School _____ Occupation _____

Emergency Contact Name _____ Relationship _____

Phone _____

How did you hear about our office? _____

Who is responsible for this account? _____ Relationship _____

INSURANCE INFORMATION

Do you have insurance that we will be filing on your behalf? YES NO

Medical Insurance Company _____ ID Number _____

Name of Primary _____ Date of Birth _____ SS# _____

Relationship to Primary: ☐ Self ☐ Spouse ☐ Partner ☐ Child ☐ Other _____

Vision Insurance Company _____ ID Number _____

Name of Primary _____ Date of Birth _____ SS# _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Partner ☐ Child ☐ Other _____

****** IF YOU HAVE MORE THAN TWO INSURANCES PLEASE LET US KNOW ******

I understand that my insurance is an agreement between me and my insurance company and that I am responsible for my balance regardless of my insurance. I understand that I am responsible for any co-payments or deductible amounts dictated by my insurance company. I assign benefit payments to be paid directly to Kaluzne Vision Care from my insurance company.

Patient's (Parent's) Signature _____ Date _____

I acknowledge that I was offered/received a copy of the HIPPA/Kaluzne Vision Care's Notice of Privacy Practices.

Patient's (Parent's) Signature _____ Date _____