# WELCOME TO OUR OFFICE

PATIENT INFORMATION: :

LAST NAME _____ FIRST NAME _____ MID _____

ADDRESS _____APT_____CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ GENDER _____ MARITAL STATUS: S M W D
EMAIL: _____

CELL _____ HOME _____ WORK _____

OCCUPATION _____
EMPLOYER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

REASON FOR VISIT: ___ ROUTINE ___ CATARACT _____OTHER: _____

REFERRED BY: _____ INTERNIST _____
ADDRESS _____ PHONE _____

PHARMACY _____ ADDRESS _____ZIP CODE_____
PHONE _____

## INSURANCE INFORMATION

NAME OF INSURANCE COMPANY
_____

GUARANTOR LAST NAME_____ FIRST NAME _____
INT _____

GUARANTOR DATE OF BIRTH _____ PATIENT ID# _____ GROUP #_____

PATIENT'S DATE OF BIRTH _____ RELATIONSHIP TO INSURED ____ SELF ___ SPOUSE ___CHILD ___ OTHER

MEDICAL CLAIMS ADRESS PO BOX _____ CITY_____
STATE_____ ZIP_____

## EMERGENCY CONTACT

CONTACT PERSON _____ PHONE _____ RELATION _____

## NOTE:

**PLEASE BE ADVISED, YOU ARE RESPONSIBLE FOR SERVICES RENDERED THAT ARE NOT COVERED BY INSURANCE. SUCH AS REFRACTIONS, COPAYS,**
**DEDUCTIBLES, CO-INSURANCE OUT OF POCKET COST AND ANY HOSPITAL FEES ASSOCIATED WITH SURGERY.**

I, _____ HAVE READ THE STATEMENT ABOVE. I AM FULLY AWARE AND UNDERSTAND MY
(PRINT NAME)
RESPONSIBILTY TO DR. KAHANOWICZ.

**SIGNATURE** _____ **DATE** _____