

KOBY KARP DOCTORS EYE INSTITUTE
New Patient Information

PERSONAL INFORMATION (please print)

Name _____ Date _____
Date of Birth _____ Age _____ M/F _____ Soc Security # _____
Address _____
Street City State Zip
Phone: Home _____ Work _____
Occupation _____ Employer _____
Address _____ Phone _____
Marital Status: Single Married Widowed Divorced
Spouse Name _____ Employer _____
Spouse date of birth _____ Spouse Social Security # _____
Responsible Party (if different from above) _____
Relationship to Patient _____ DOB _____ Soc Security # _____
Address _____ Phone _____
Primary Care Physician _____
Reason for Visit _____
How did you hear about our practice? _____

INSURANCE INFORMATION

Primary Ins. _____ Secondary Ins. _____
ID# _____ Grp# _____ ID# _____ Grp# _____
 Workers Compensation (job injury) to whom is bill sent? _____
 Other Medical Insurance: Group # _____ ID# _____
Name/Address Insurance _____
Name of nearest relative/friend not living with you _____
Address _____
Home Phone _____ Work Phone _____

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amounts, co-payments, co-insurance, or any other balance not paid for by your insurance.
2. In Order To Control Your Cost Of Billings, We Request That Your Charges For Office Visits Be Paid At The Conclusion Of Each Visit Unless You Are Covered By Medicare.
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information about me to release to Centers for Medicare & Medicaid Services (formerly HCFA), its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. 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. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release information necessary to secure the payment.

Signed (Patient or parent for minor) _____ Date _____