

PATIENT INFORMATION

Patient's Name (Last, First, Middle Initial) _____

Address _____

City _____ State _____ Zip Code _____ Home Phone _____

Employer _____ Occupation _____

Address _____

City _____ State _____ Zip Code _____ Bus. Phone _____

Cell Phone _____ Email address _____

Social Security Number _____ Date of Birth _____ Age _____

Sex : Male / Female Marital Status : S M W D

Family Doctor : _____

Referred By (please circle) Insurance/ Patient/ Physician/ Optometrist/ Other

Name _____ Insurance Co . _____

.....
Name of person responsible for the bill or holder of Insurance Policy
(If different from Patient)

Name _____ Date of Birth _____

Address _____ City/State/Zip _____

Home Phone _____ Business Phone _____

Employer _____

Relationship of patient to Insured : Self Spouse Child Other _____

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Please provide us with your insurance Card so we may make a photocopy

Name of Primary Insurance _____

Name of Secondary Insurance _____

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I request that payment of authorized benefits be made on my behalf to Richard S. Kalski, M.D., P.A. for any services furnished. I authorize Richard S. Kalski, M.D., Darrel J. Mase Jr. M.D., to release to my insurance company, its agents, or any other supplier of medical benefits, any information needed to determine those benefits, or the benefits payable for related services.

I understand that if I am seen without a referral from my primary care physician and my health plan requires that I obtain that referral, then my health plan may not cover the charges, costs, or expenses of my examination by Richard S. Kalski, MD., Darrel J. Mase, Jr. M.D. In that case, I will be responsible for paying my bill.

REFRACTIONS: (The procedure to check or determine your eyeglass prescription is not covered by Medicare and most insurance companies). There will be a \$35.00 charge to the patient for all refractions. Please notify the technician, if you do not wish to have a refraction.

Signature-Patient or Authorized party

Today's date