PATIENT REGISTRATION

(PLEASE PRINT)

Kunesh Eye Center, Inc.

Integrity ● Technology ● Compassion

□ KKP □ NP
□ MTK □ NEW PATIENT #_____
□ JCK

PHONE 937-298-1703
FAX 937-298-6344
2601 FAR HILLS AVENUE
DAYTON, OHIO 45419-1665

PATIENT INFORMATION:

□ Mr. □ Rev. □ Dr. _____ (i.e. M.D., Ph.D.)
□ Mrs. □ Fr.
□ Miss □ Bro.
□ Ms. □ Sr.

□ Married
□ Single
□ Widowed
□ Divorced
□ Legally Separated
□ Life Partner

How did you hear about our office?

□ Dr. _____
□ Friend
□ Relative
□ Other: _____

NAME: _____ DATE OF BIRTH: _____ AGE: _____
LAST FIRST M.I

ADDRESS: _____ CITY:_____STATE: _____ ZIP _____ - _____

HOME PH#: _____ CELL PH #: _____ SOC. SEC. # _____-_____-_____

EMAIL: _____

RACE:
□ AMERICAN INDIAN OR ALASKA NATIVE
□ ASIAN
□ BLACK OR AFRICAN AMERICAN
□ NATIVE HAWAIIAN
□ OTHER PACIFIC ISLANDER
□ WHITE
□ UNREPORTED/UNKNOWN

LANGUAGE:
□ ARABIC
□ BULGARIAN
□ SPANISH, CASTILIAN
□ CHINESE
□ ENGLISH
□ FRENCH
□ GERMAN
□ HAITIAN; HAITIAN CREOLE
□ HEBREW
□ HINDI
□ ITALIAN
□ JAPANESE
□ KOREAN
□ POLISH
□ PORTUGUESE
□ RUSSIAN

ETHNICITY: □ NOT HISPANIC □ UNKNOWN ETHNICITY □ LATINO OR HISPANIC

EMPLOYMENT STATUS

EMPLOYER: _____ BUSINESS PH #: _____

EMPLOYER'S ADDRESS: _____ CITY/STATE_____ ZIP_____

RETIRED □ YES □ NO RETIRED FROM: _____

SPOUSE INFORMATION

NAME: _____ SOC. SEC #: # _____-_____-_____DATE OF BIRTH: _____

EMPLOYER: _____ BUSINESS PH # _____

EMPLOYER'S ADDRESS:_____ CITY/STATE_____ ZIP_____

EMERGENCY CONTACT INFORMATION

NEAREST RELATIVE: _____ RELATIONSHIP:_____
(OTHER THAN SPOUSE)

RELATIVES HOME PH # _____ BUSINESS PH #: _____CELL PH# _____

INSURANCE INFORMATION:

Primary (1st) Insurance _____

Policy # _____ Group name and # _____

Secondary (2nd) Insurance _____

Policy # _____ Group name and # _____

Tertiary (3rd) Insurance _____

Policy # _____ Group name and # _____

AUTHORIZATION FOR BILLING OF PROFESSIONAL SERVICES PROVIDED BY: KUNESH EYE CENTER, INC.

MEDICARE AUTHORIZATION TO RELEASE INFORMATION AND TO CLAIM PAYMENT

I request that payment of authorized Medicare benefits be made on my behalf to Kunesh Eye Center, Inc., for services furnished me by Kunesh Eye Center, Inc. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Kunesh Eye Center, Inc. accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. I understand that coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

Signature _____ Date _____

MEDIGAP AUTHORIZATION TO RELEASE INFORMATION AND TO CLAIM PAYMENT

I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Kunesh Eye Center, Inc., if possible, or otherwise to me.

Signature _____ Date _____

INSURANCE AUTHORIZATION TO RELEASE INFORMATION AND TO CLAIM PAYMENT

I permanently authorize any holder of medical and other information about me to release that information to my insurance company. A photocopy of my signature may be used to file for insurance benefits. I also request the payment of benefits be made on my behalf to me or the above-mentioned provider who may accept assignment.

Signature _____ Date _____