PATIENT REGISTRATION
(PLEASE PRINT)

Kunesh Eye Center, Inc.
Integrity • Technology • Compassion

2601 Far Hills Ave
Dayton, OH 45419-1665
Phone: 937-298-1703
Fax: 937-298-6344

Patient Information:

❑ Mr. ❑ Rev. ❑ Dr. _____ (i.e. M.D., Ph.D)
❑ Mrs. ❑ Father
❑ Miss. ❑ Brother
❑ Ms. ❑ Sister

❑ 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: _____ Occupation: _____

Spouse Information

Name: _____ Soc Sec#: _____ - _____ - _____ Date of Birth: _____
Employer: _____ Business Ph#: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____

Insurance Information

Primary (1st) Insurance _____
Policy # _____ Group name and # _____
Secondary (2nd) Insurance _____
Policy # _____ Group name and # _____

Appointment reminders, account information and notification program: I agree to receive emails and/or text messages regarding appointment reminders, account balances/statements, clinic related notifications (such as recall notices) on the phone number/email provided. I understand that message and data rates may apply.

Authorization for Treatment: I authorize examination, diagnosis, and general treatment (including, but not limited to, non-invasive procedures such as diagnostic tests) to be performed by physicians and staff of Kunesh Eye Center, Inc. I realize that if a medical procedure or surgery is required, I will be given additional information.

Telephone Consumer Protection Act (TCPA) Consent: I agree, for Kunesh Eye Center, Inc. to service my account or to collect any amounts I may owe, Kunesh Eye Center, Inc. may contact me via telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Methods of contact may include sending an email or a text message and/or using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that Kunesh Eye Center, Inc., or any entity authorized by Kunesh Eye Center, Inc. may contact me as described above.

Consent for Digital Communications: By providing my telephone number or email address to Kunesh Eye Center, Inc. on this Patient Registration form, or verbally, I agree to receive automated calls, prerecorded messages, text messages, and/or emails related to my health care from Kunesh Eye Center, Inc. and its affiliates. I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing.

Insurance, Payment Information and Assignment of benefits: I request that Kunesh Eye Center, Inc. submit claims on my behalf to my insurance company, Medicare or other third-party payer for my care and authorize the disclosure of health information to the extent necessary to obtain payment for all services. I assign and authorize my insurance company, Medicare or other third-party payer to make payments directly to Kunesh Eye Center, Inc. A photocopy of my signature may be used to file for insurance benefits.

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations: I consent to Kunesh Eye Center, Inc. using and disclosing my protected health information regarding diagnoses, treatment, consultations, prescriptions, and medical history to carry out treatment, payment, or health care operations.

Kunesh Eye Center, Inc. may use any information provided on this form to communicate with me.

I understand and have been offered a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that Kunesh Eye Center, Inc. reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting one.

I hereby authorize any holder of medical information about me to release to my insurance company, the Centers for Medicare/Medicaid services, or other third-party payer and its agents any information needed to determine those benefits payable for related services. I hereby authorize my insurance company, Medicare/Medicaid to furnish to Kunesh Eye Center, Inc. any information regarding my Medicare clams under title XVII and XIX of the Social Security Act.

✖ _____ ✖ _____

Signature of Patient Date

✖ _____

Printed Name of Patient