PATIENT DEMOGRAPHIC INFORMATION

PLEASE PRINT CLEARLY **COMPLETE ALL INFORMATION**

PATIENT'S FULL NAME _____GENDER: MALE / FEMALE

DATE OF BIRTH_____ AGE_____ MARITAL STATUS_____ SSN_____

HOME ADDRESS (in the US)_____

CITY _____ STATE_____ ZIP CODE_____

HOME PH_____ WORK. PH _____ CELL PH. -_____

EMAIL_____

NAME OF INSURANCE_____

FULL NAME OF POLICY HOLDER_____

POLICY NUMBER _____POLICY HOLDER DOB_____

EMERGENCY CONTACT

PERSON TO CONTACT INCASE OF AN EMERGENCY_____

RELATIONSHIP TO PATIENT _____PHONE NUMBER_____

EMPLOYER INFORMATION

EMPLOYER NAME_____OCCUPATION_____

ADDRESS_____

CITY_____STATE_____ZIPCODE_____PHONE #_____

PREFERRED APPOINTMENT REMINDER METHOD: TEXT CALL (CELL) CALL (HOME)

WHO REFERRED YOU TO US? _____

WOULD YOU BE INTERESTED IN BOTOX, FILLERS? YES NO

WOULD YOU BE INTERESTED IN LASIK? YES NO

I acknowledge that I have read and understand the notice of privacy practices and all the information above is correct. I authorize KOTECHA EYE & LASER CENTER, PLLC (CAPITAL VISION) or its billing agents to submit claims on my behalf to my insurance carrier with payment of insurance benefits being paid to Kotecha Eye & Laser Center. I permit a copy of this authorization to be used in place of my original signature and authorize any holder of medical information about me to be release to the Health Care Financing Administration or its agents or other insurance companies, any information needed to determine benefits payable as outlines by HIPAA. I will be fully responsible for payment if insurance denies reimbursement. I will be responsible for payment of fees in the event I have failed to provide my most current **insurance information or referral** at any visit. Also I will be responsible for collection fees if my account is beyond 90 days past due and sent to the collection agency.

_____ _____

PATIENT'S SIGNATURE DATE

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