

PATIENT IDENTIFICATION –PLEASE PRINT

PATIENT FIRST NAME	MIDDLE INITIAL	LAST NAME	
DATE OF BIRTH	STREET ADDRESS		
CITY	STATE	ZIPCODE	SOCIAL SECURITY #
HOME PHONE	BUSINESS PHONE	CELL PHONE	OCCUPATION
EMPLOYER'S NAME	ADDRESS		PHONE #
HOW DID YOU HEAR ABOUT OUR OFFICE?			
NAME OF FAMILY DOCTOR		IF REFERRED BY:	

FINANCIAL RESPONSIBILITY –Write "Self" if appropriate

LAST NAME	FIRST	MIDDLE INITIAL	
ADDRESS	CITY	STATE	ZIP
PHONE #	DATE OF BIRTH	RELATIONSHIP TO PATIENT	

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE COMPANY	NAME OF SUPPLIMENTAL INSURANCE CO
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I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE ABOVE NAMED PATIENT.
 I AUTHORIZE THE REALEASE OF ALL MEDICAL RECORDS TO THE REFERRING AND FAMILY PHYSICIANS AND TO MY INSURANCE COMPANY, IF APPLICABLE.
 I ALLOW FAX TRANSMITTAL OF MY MEDICAL RECORDS, IF NECESSARY.
 I TAKE FULL FIANANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY DR. KRIEG OR DR. KOHLI.
 I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER DEFINITED FINANCIAL ARRANGEMENTS HAVE BEEN MADE.
 I AGREE TO PAY ALL REASONABLE COLLECTION COSTS IN THE EVENT OF DEFAULT PAYMENT.
 I FURTHER AUTHORIZE AND REQUEST AS A ONE TIME SIGNATURE THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO U.P. OPHTHALMOLOGY UNTIL OTHERWISE STATED.
 BY SIGNING THIS STATEMENT I HAVE CONSENTED FOR TREATMENT, FIANANCIAL RESPONSIBILITY, RELEASE OF MEDICAL INFORMATION, AND INSURANCE AUTHORIZATION AS LONG AS I AM UNDER THE CARE OF U.P. OPHTHALMOLOGY.

Date: _____ Signature _____