DARRELL J. KOHLI, M.D
JAYLENE K. IVERSON, O.D.

U.P. Ophthalmology

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Escanaba, MI 49829
(906) 786-5181

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/REFERRAL			
NAME OF FAMILY DOCTOR			EMAIL ADDRESS

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

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

Date:_____Signature_____