

PLEASE COMPLETE (ALL INFORMATION IS REQUIRED)

Name: _____ Sex: _____ Birth Date: _____

Mailing Address: _____ Phone: Home: _____

City, State, Zip: _____ Work : _____

SSN: _____ Cell : _____

Family Doctor: _____ Occupation: _____

Spouse's Name: _____ Employer: _____

Spouse's Employer: _____

In Case of Emergency Contact / Someone Other Than Household Member: _____

- Patient Status:** Married Single Divorced Widow/ Widower
 Full-Time Student Part-Time Student

Today's Visit:

How did you hear about us: _____

If referred, by whom : _____

Routine Vision Plan : _____

OR

Medical Reason : _____

Insurance Information

Name of Policy Holder: _____ SSN: _____ DOB: _____

Address: _____ Telephone: _____

Primary Insurance : _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Patient's relationship to primary insured: () Self () Spouse () Child () Other _____

PLEASE READ CAREFULLY

Drs. John C. Kulze and Charles Beischel are Medicare providers and participate in most insurance plans. Patients will be responsible for any co-payments, deductibles, non-authorized or non-covered services as defined by your individual insurance plan. Patients without a health insurance plan or one in which we do not participate will be expected to render payment at the time of service unless arrangements have been made in advance. Upon request a statement will be provided for you to present to your insurance carrier for reimbursement.

I hereby authorize release of my medical information necessary to process insurance claims for services rendered and request that of benefits be made either to myself or the party that accepts assignment. I understand that I am Financially responsible for all charges not paid by my insurance carrier. Acopy of this authorization shall remain on file for all future treatment. I further authorize said assignee to release all information to secure payment.

I also authorize Drs. Kulze and Beischel to obtain information from other physicians they feel necessary and beneficial to evaluate and treat my condition, in addition, I authorize them to use my medical information on file to participate in research drug study programs.

A copy of this authorization will be as valid as the original.

Name _____ Date _____

Name _____ Date _____