KALUZNE VISION CARE

PATIENT INFORMATION

NAME (LAST)	SUFFIX	FIRST	M.I.

MAILING ADDRESS	CITY	STATE	ZIP

HOME PHONE #	CELL # or ALTERNATE #	SEX M F	DATE OF BIRTH	SOCIAL SECURITY #

EMAIL ADDRESS	COMMUNICATION PREFERENCE (circle) PHONE E-MAIL TEXT MAIL	RACE	ETHNICITY

PATIENT'S EMPLOYER	ADDRESS	WORK #

MARITAL STATUS	SPOUSE'S NAME	SPOUSE'S DATE OF BIRTH	SPOUSE'S SOCIAL SECURITY #

PRIMARY CARE PHYSICIAN OR MEDICAL DOCTOR	ADDRESS & PHONE # OF DOCTOR

NAME OF PHARMACY YOU ARE CURRENTLY USING	PHARMACY LOCATION OR ADDRESS

NAME OF OPTOMETRIST OR LAST EYE DOCTOR YOU SAW	ADDRESS & PHONE # OF DOCTOR

RESPONSIBLE PARTY INFORMATION (complete ONLY if different from above information.)
Must be completed if patient is under 18 years old.

NAME (LAST)	FIRST	M.I.

MAILING ADDRESS	CITY	STATE	ZIP

HOME PHONE #	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY #

EMPLOYER	EMPLOYER ADDRESS	EMPLOYER PHONE #

INSURANCE INFORMATION (Please bring insurance cards to appointment)

VISION INSURANCE	POLICY #

POLICY HOLDER'S NAME	POLICY HOLDER'S BIRTHDATE	POLICY HOLDER'S SOCIAL SECURITY #

RELATIONSHIP TO PATIENT	POLICY HOLDER'S EMPLOYER & ADDRESS

PRIMARY MEDICAL INSURANCE	POLICY #

POLICY HOLDER'S NAME	POLICY HOLDER'S BIRTHDATE	POLICY HOLDER'S SOCIAL SECURITY #

RELATIONSHIP TO PATIENT	POLICY HOLDER'S EMPLOYER

SECONDARY MEDICAL INSURANCE	POLICY #

POLICY HOLDER'S NAME	POLICY HOLDER'S BIRTHDATE	POLICY HOLDER'S SOCIAL SECURITY #

RELATIONSHIP TO PATIENT	POLICY HOLDER'S EMPLOYER

How did you learn about our office? (Please check one)

_____ Friend/Family (Who)_____ _____ Medical Doctor _____ Other

_____ Previous Patient (Who)_____ _____ Yellow Pages

I understand that my insurance is an agreement between me and my insurance company and that I am responsible for my balance regardless of my insurance. I assign benefit payments to be paid directly to Dr. Kaluzne from my insurance company.
Patient's (Parent's) Signature_____Date_____