

**KEAMY EYE AND LASER CENTER
PATIENT CONFIDENTIAL INFORMATION**

Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

E-Mail Address _____ Sex: Male Female

SSN: _____ Occupation: _____

Date of Last Eye Exam: _____ Doctor's Name: _____

Notify in case of emergency: _____ Phone Number _____

How did you hear about our office? _____

Primary Physician Information

Primary Physician: _____ Primary Physician Number: _____

Insurance Information

Name of insurance: _____

Insurance ID number: _____ Group number: _____

Policyholder name: _____ Relationship to policyholder: _____

Policy holder SSN: _____ Policyholder Date of Birth _____

Policyholder Employer: _____ Work Number: _____

Home Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____

Second Insurance: _____

Insurance ID number: _____ Group number _____

Release of information: I hereby authorize Keamy Eye and Laser Centre to furnish and disclose all facts concerning my care to my insurance company and other physicians upon my request.

Assignment of benefits: I hereby authorize all insurance companies to make payments directly to Laser Centre or any insurance benefits for professional services rendered. I understand that I am responsible for charges not paid by my insurance company. If my insurance company requires written referral and referral for my visit, I understand I am responsible for payment of the services provided.