TODAY'S DATE_____/_____/_____

PATIENT INFORMATION

Name: _____

Address: _____

City, State, Zip: _____

Preferred Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

Alternate Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

Alternate Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

Social Security Number: _____

E-Mail Address: _____

Date of Birth:_____/_____/_____ Age:_____

Material Status:

☐ Married ☐ Single

☐ Divorced ☐ Widowed

Preferred Language:

☐ English ☐ Other:_____

Ethnicity:

☐ Not Hispanic or Latino

☐ Hispanic or Latino

☐ Unknown

Race:

☐ White ☐ Black or African American

☐ Asian ☐ American Indian or Alaskan Native

☐ Native Hawaiian or Other Pacific Islander

☐ Other

PATIENT'S EMPLOYMENT INFORMATION

Employer's Name: _____

Employer's Phone: (_____)_____

Occupation: _____

☐ Employed ☐ Retired

☐ Student/Child ☐ Unemployed

PRIMARY INSURANCE INFORMATION

Insurance Company Name:_____

ID#: _____

Subscriber Name: _____

Subscriber's SS#: _____

Relationship to Patient:_____

Subscriber's Date of Birth: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____

ID#:_____

Subscriber Name: _____

Subscriber's SS#: _____

Relationship to Patient:_____

Subscriber's Date of Birth:_____

***** PLEASE BRING INSURANCE CARDS AND DRIVER'S LICENSE TO FRONT DESK *****

PRIMARY INSURANCE INFORMATION

Referring Physician: _____

Address: _____

Phone: (_____)_____

Primary Care Physician:_____

Address: _____

Phone: (_____) _____

Financial Policy Statement

Welcome to Kensington Ophthalmology, we are pleased you have chosen our practice for your medical care. We are committed to providing you with the highest quality services available. Please read and sign the following policy. If we are contracted with your insurance company, we will accept assignment. **All co-pays, co-insurance and deductibles are due and payable at time of service. Failure to provide necessary referrals or current accurate billing information will result in all charges for services being the sole responsibility of the patient/responsible party.** You are expected to understand your benefits coverage and financial responsibility. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payment at time of service. You will be responsible for any balances not covered by your insurance. A return check fee of $25 will be assessed if your check is returned by your bank.

Patient/Guardian Signature_____ **Date:** _____