Kellis Eye & Laser Center - Patient Registration Form

Name:_____ Social Security #:_____
(Last) (First) (M.I.)

Mailing Address:_____
(Street or PO Box Number & Name) (City) (State) (Zip Code)

DOB:_____/_____/_____ Age:_____ Sex: M F Marital Status: S M Other Race: _____ Ethnicity:_____

Home Phone:_____ Cell Phone:_____ Ok to send text message: Yes / No

Email address: _____

Employer:_____Occupation:_____ Phone: _____

Family Physician:_____Phone :_____

Referring Provider: _____ Cardiologist: _____

Emergency Contact: _____ Relation : _____ Phone: _____

If you were not referred, please tell us how you heard about us: ❒ Friend ❒Family ❒Website ❒Social Media

Responsible Party & Privacy Information

Name:_____ Relation to Patient:_____
(Last) (First) (M.I.)

Billing Address:_____Phone: _____
(Street or PO Box Number & Name) (City) (State) (ZipCode)

**Can we leave a message on your voicemail or answering machine pertaining to your care? Yes / No

**Do we have your permission to share your medical information with your spouse? Yes / No

**Do we have your permission to share medical information with anyone else? Yes / No

**If so, who? _____ Relation: _____ Phone: _____

Insurance and Billing Information (It is YOUR responsibility to inform us of any changes in your coverage)

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder: _____ Policy Holder: _____

Social Security #: _____ Social Security #: _____

Date of Birth: _____ Date of Birth: _____

Relation to Patient: _____ Relation to Patient: _____

****If you have one of the following vision insurance plans, please circle and specify policy holder name.****

VSP EyeMed Policy Holder: _____

I certify that I, and/or my dependent(s), have insurance coverage with those listed above and assign directly to Ophthalmology & Oculoplastic Surgery, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named practice may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable to related services. I acknowledge that I understand the Privacy Policies of this office. (A copy of the Notice of Privacy Practices is available upon request.)

Signature_____ **Date**_____