KOBY KARP DOCTORS EYE INSTITUTE 4004 DUPONT CIRCLE • LOUISVILLE, KY 40207

NEW PATIENT INFORMATION

Name_____**Date**_____
Date of Birth _____**Age** _____**M/F** _____**Social Security#** _____
Adress_____
Street City State Zip
Phone: Home _____ **Work**_____ **Email Add** _____
Occupation _____ **Employer** _____
Address _____ **Work Phone** _____
Marital Status: ____**Single** ____**Married** _____**Widowed** _____**Divorced**

Responsible Party (if different from above) _____
Relationship to Patient _____ **DOB** _____ **Soc Security #** _____
Address _____ **Phone** _____
Primary Care Physician _____
Reason for Visit _____
How did you hear about our practice? _____

INSURANCE INFORMATION

Primary Ins. _____ **Secondary Ins.** _____
ID# _____ **Grp #**_____ **ID#** _____ **Grp #** _____
Workers Compensation (job injury) to whom is bill sent? _____
Other Medical Insurance: Grp# _____ **ID#** _____
Name/Address Insurance _____
Name of nearest relative/friend not living with you _____
Address _____
Home Phone _____ **Work Phone** _____

Financial Assignment and Agreement:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amounts, co-payments, co-insurance, or any other balance not paid for by your insurance.**

2. IN ORDER TO CONTROL YOU COST OF BILLINGS, WE REQUEST THAT YOUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT UNLESS YOU ARE COVERED BY MEDICARE.

3. I request that payment of authorized Medicare and/or insurance benefits be make on my behalf for any services furnished to me. I authorize any holder of medical information about me to release to Centers for Medicare & Medicaid Services (formerly HCFA), its agents or any insurance carrier I may have , any information needed to determine these benefits payable for related services.

4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release information necessary to secure the payment.

Signed (Patient or parent for minor) _____ **Date** _____