MONTGOMERY EYE PHYSICIANS & SURGEONS
HOWARD KANE, O.D., M.D.
KRISTEN C. ZELLER, M.D.
YUN JA PARK, M.D.

Name: ______________________ Social Security #: ______________

Date of Birth: __________ Marital Status: ______ Male: _____ Female: _____

Street Address: ______________________________ Apt #: _______

City: ______________________ State: ________ Zip: ________

Mailing Address (if different): ______________________________

Home Phone: (______)______________ Cell Phone: (______) ______________

Work Phone: (______) ______________

Emergency Contact Name/Relationship: ________________ Phone: ____________

Medical Doctor: ______________________ Phone: ____________

Address: ____

Who referred you to this practice? ______________________________

Do you have vision coverage with your insurance? ______________________

Do you need a referral for this visit from your primary care doctor? ______________

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PRIMARY INSURANCE:

Primary Insurance Co: ________________

Address: ________________

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Policy #: ________________

Group #: ________________

Policy Holder: ________________

Relation to patient (please circle one):

Self Spouse Child Other: ________

SECONDARY INSURANCE:

Secondary Insurance Co.: ________________

Address: ________________

____

Policy #: ________________

Group #: ________________

Policy Holder: ________________

Relation to patient (please circle one):

Self Spouse Child Other: ________

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GUARANTOR:

Relation to patient (please circle one): Self Spouse Parent Other: __________

Name: ______________________ Social Security #: ______________

Date of Birth: __________ Male: __________ Female: __________

Street Address: ______________________________ Apt #: _______

City: ______________________ State: ________ Zip: ________

Mailing Address (if different): ______________________________

Home Phone: (______)______________ Work Phone: (______)______________

Employer Name & Address: ______________________________

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AUTHORIZATION: I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITY. I AUTHORIZE MY DOCTOR TO PROVIDE MY INSURANCE COMPANY WITH ANY REQUESTED MEDICAL INFORMATION. I UNDERSTAND MY INSURANCE COMPANY DOES NOT GUARANTEE PAYMENT OF SERVICES.

A $25.00 FEE WILL BE CHARGED FOR MISSED APPOINTMENTS WITHOUT 24 HOURS NOTICE.

Patient/responsible party signature: ______________________ Date: __________