Advanced Ophthalmology Associates PLC
Barbara M. Kuczynski, M.D.
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Patient Information

Legal Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip code: _____

Date of Birth: _____ Age: _____ Gender: _____ SS # _____

Cell Phone Number: _____ Home Phone Number: _____

Marital Status S M W D How did you hear about us? _____

Emergency Contact: Name _____Phone Number_____

Employer (self) _____ Employer (spouse) _____

Primary Care Physician: Dr. _____ Referring Physician: Dr._____

Pharmacy Name and Location: _____

NAME OF PRIMARY INSURANCE: _____

Contract/ID/ACCT# _____ Group Number: _____

If Other Than Self:

Policy Holder's Name: _____ Relationship: _____

Date of Birth: _____ Social Security #: _____

NAME OF SECONDARY INSURANCE: _____

Contract/ID/ACCT # _____ Group Number: _____

If Other Than Self:

Policy Holder's Name: _____ Relationship: _____

Date of Birth: _____ Social Security #: _____

VISION INSURANCE OR OTHER MEDICAL INSURANCE: _____

Contract/ID/ACCT # _____ Group Number: _____

If Other Than Self:

Policy Holder's Name: _____ Relationship: _____

Date of Birth: _____ Social Security #: _____

Is this Workman's Compensation? Yes/ No Date of Injury and Person to Contact _____

Is This the Result of an Auto Accident? Yes / No

With Whom May We Discuss Your Medical Condition With? (I.E. a spouse, child, parent, sibling, or guardian)

_____

I authorize the release of any medical information necessary to process claims and authorize payment of benefits to Barbara M. Kuczynski, M.D. Advanced Ophthalmology Associates PLC. I understand I am responsible for any unpaid balance remaining on my account after insurance payment or in the case of insurance rejection.

Patient Signature: _____Date:_____