Advanced Ophthalmology Associates PLC
Barbara M. Kuczynski, M.D.
330 East Fourteen Mile Road, Suite B Clawson, MI 48017 Phone (248) 589-9500 Fax (248) 589-9587

PERSONAL INFORMATION

Name of Patient_____ Date_____

Address_____

City_____State_____Zipcode_____

Date of Birth_____Age_____M/F_____S.S#_____

Home Phone_____Alt. phone_____

Marital Status S M W D Person to Notify in Emergency_____

Emergency Contact Telephone_____

Who Referred you to this office?_____

INSURANCE

Who is the insurance through? Self_____ Spouse_____ Other_____

IF OTHER THAN SELF Name_____ Relationship_____

Date of Birth_____ S.S # _____

Employer (self)_____Telephone_____

Employer (spouse)_____Telephone_____

Medicare #_____Blue Shield Information/Card Holder Name_____

Contract #_____ Group_____

Other Insurance

Name of Insurance Company_____ Contract #_____

Group #_____ Address of Insurance Company_____

Is this Workmans Compensation? Yes_____ No____ Date of Injury_____

Auto Accident? Yes__ No__ Date of Accident_____ Insurance Name_____

Claim Number_____ Contact Person_____ Telephone_____

Do you have Vision Insurance? Yes__ No__ Name of Insurance_____

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 (parent or guardian)_____ Date_____