Welcome To Our Practice

Kenneth P. Adams, DO., PC. *is committed to excellence in ophthalmology and appreciate you taking the time to complete this confidential registration form . The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us we will be happy to help.*

Patient Information

_____
First Last Middle Initial

_____
Preferred Name

_____/_____/_____ _____ _____
Birth date Age SS#

[]Single [] Married [] Child {} Other [] Male [] Female

_____
Home Address

_____
City State Zip

_____
Employer

_____
Occupation

Whom can we thank for referring you?

_____

Phone Numbers

Home Phone:_____ Work Phone:_____

Cell:_____ Other:_____

Email Address:_____

EMERGENCY CONTACT:

Name:_____

Relationship:_____

Home:_____ Work:_____

Cell: _____ Other:_____

Insurance Information

Who is responsible for this account ?_____

Relationship to patient:_____ Subscriber:_____

Birth date:____/_____/_____ SS#_____ Employer:_____

Insurance Company:_____ ID#_____ Group#_____

Is patient covered by additional insurance? [] YES [] NO

Insurance Company:_____ ID#_____ Group#_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependant) have insurance coverage and assign directly to KENNETH P. ADAMS, DO., PC. 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 hereby authorize this facility to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date