ARROWHEAD EYE CENTER
RICHARD M. KOOTMAN, M.D., P.C.

WELCOME TO OUR PRACTICE!

NAME:____ HOME PHONE:___________________________

ADDRESS:_____________________________________ WORK / CELL:__________________________

CITY:______________________ STATE:_______ZIP:__________EMAIL:_________________________

SEX:_________DATE OF BIRTH:____/____/____ AGE:_____SOCIAL SECURITY #______________________

MARITAL STATUS:_______ _EMPLOYER:______________________REFERRED BY:___________________

INSURED (Card Holder / Responsible Party if not patient)

NAME:____ RELATIONSHIP TO PT:_______________________

ADDRESS:______________________________________ DATE OF BIRTH:____/____/____

CITY:______________________STATE:________ZIP:_________SOCIAL SECURITY #____________________

EMPLOYER:____________________HOME PHONE___________________WORK PHONE________________

INSURANCE INFORMATION

PRIMARY

NAME:___________________________________

ADDRESS:________________________________

____

I.D.#_________________GROUP#______________

NAME OF INSURED:_________________________

BIRTHDATE OF INS: ___/___/___

SECONDARY

NAME:___________________________________

ADDRESS:________________________________

____

I.D.#__________________GROUP#_____________

NAME OF INSURED:_________________________

BIRTHDATE OF INS:___/___/___

EMERGENCY CONTACT (NOT LIVING WITH YOU)

NAME:________________________________RELATIONSHIP:________________PHONE:__________________

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. FURTHER, I AGREE TO PAY FOR SERVICES RENDERED WHEN CHARGES ARE INCURRED I THE OF EVENT OF DEFAULT. I PROMISE TO PAY LEGAL, INTERESTON THE INDEBTEDNESS, TOGETHER WITH SUCH COLLECTION COSTS AND ATTORNEY FEES AS MAY BE REQUIRED TO COLLECT THIS AMOUNT.

RESPONSIBLE PARTY SIGNATURE___________________________________ DATE_____________________