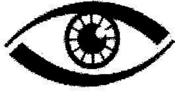

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Karlik Ophthalmology

Jeffrey S. Karlik, M.D. *Troy M. Karlik, D.O.* *David J. Kobaly, M.D.* *Steve Rogers, M.D.*

PATIENT INFORMATION

Name____Date_____________________
(last) (first) (middle)
Address______________________________ Male Female
______________________________ Single Married Divorced Widowed
____
(city) (state) (zip)

Social Security # _______________________Birthdate______________________________
Occupation____________________________Employer Name________________________
Home Phone___________________________Work Phone____________________________
If Work Related, Date of Injury___________Cell Phone ____________________________
Emergency Contact Person/Phone Number ________________________/_______________

Name of Insurance______________________
Name on the Card_______________________Relationship to PolicyHolder______________
If Policy Holder is not Self:
Name of Policy Holder_________________
Birthdate of Policy Holder_______________
SS # of Policy Holder___________________
Address and Phone Number of Policy Holder (if different than yours):
____
____
Primary Care Physician _______________________________________

ASSIGNMENT OF BENEFITS:

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT.

SIGNED____DATE____________________

Patient email address:____

Medical and Surgical Eye Care