CENTER FOR HEALTH AND VISION **KENNETH L. MALAMUD, M.D., PLLC**

PATIENT'S NAME:_____

HOME PHONE: ( )_____ **CELL PHONE**: ( )_____

ADDRESS: _____

STREET CITY STATE ZIP CODE

SEX: MALE/FEMALE **MARITAL STATUS**: SINGLE MARRIED DIVORCED SEPARATED WIDOWED

RACE: AFRICAN-AMERICAN ASIAN-AMERICAN CAUCASIAN NATIVE-AMERICAN OTHER_____

ETHNICITY: HISPANIC NON-HISPANIC **PREFERRED LANGUAGE**:_____

SOCIAL SECURITY #: _____-_____-_____ **DRIVER'S LIC. #:**_____

DATE OF BIRTH: _____ **AGE**: _____ **EMAIL ADDRESS**: _____

EMPLOYER: _____ **PHONE**: ( )_____

ADDRESS:_____

SPOUSE/PARENT NAME:_____**PHONE :** ( )_____

EMPLOYER:_____**PHONE :** ( )_____

PRIMARY CARE PHYSICIAN:_____ **PHONE** : ( )_____

PHARMACY:_____**PHONE** : ( )_____

HOW DID YOU HEAR ABOUT OUR OFFICE?_____

FINANCIALLY RESPONSIBLE PERSON

NAME:_____ **RELATIONSHIP**:_____ **SS#:**_____

ADDRESS:_____

HOME PHONE: ( )_____ **WORK PHONE**:_____

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYING FOR THE AMOUNT BILLED TO ME FOR SERVICES RENDERED.

SIGNATURE: X _____ **DATE:**_____

****HEALTH INSURANCE INFORMATION AND SIGNATURES ARE REQUIRED FOR SUBMISSION****

PRIMARY INSURANCE COMPANY:_____**ID#**:_____**GROUP #:**_____

POLICY HOLDER:_____ **SS#:**_____ **DOB**:_____

RELATIONSHIP TO PATIENT:_____

SECONDARY INSURANCE COMPANY:_____**ID#**:_____**GROUP #**:_____

POLICY HOLDER:_____ **SS#:**_____ **DOB**:_____

RELATIONSHIP TO PATIENT:_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS. I ALSO REQUEST PAYMENT OF GOVERNMENT OR OTHER BENEFITS TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

SIGNATURE:_____

I AUTHORIZE PAYMENT OF BENEFITS TO MY PHYSICIAN OR SUPPLIER FOR SERVICE.

DATE:_____

SIGNATURE:_____