# PATIENT REGISTRATION

(PLEASE PRINT)

2601 Far Hills Ave
Dayton, OH 45419-1665
Phone: 937-298-1703
Fax: 937-298-6344

Integrity • Technology • Compassion

❑ MTK ❑ NP
❑ JCK ❑ New Patient# ____________
❑ JTF

**Patient Information:**

❑ Mr. ❑ Rev. ❑ Dr. __________ (i.e. M.D., Ph.D)
❑ Mrs. ❑ Fr.
❑ Miss. ❑ Bro.
❑ Ms. ❑ Sr.

❑ Married
❑ Single
❑ Widowed
❑ Divorced
❑ Legally Separated
❑ Life Partner

**How did you hear about our office?**

❑ Dr. ______________________
❑ Friend
❑ Relative
❑ Other: __________________

Name: ______________________________________ Date of Birth: ____________ Age: _______
Last First M.I.
Address: ________________________ City: ____________ State: ________ Zip: ____________
Home Ph#: ____________ Cell Ph#: ______________ Soc. Sec. # ______ - ____ - ______
Email: ________________________________________

**Race**: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Caucasian ❑ Native Hawaiian ❑ Other Pacific Islander ❑ Declined to Specify

**Language**: ❑ Arabic ❑ Bulgarian ❑ Spanish, Castillian ❑ Chinese ❑ English ❑ French ❑ German ❑ Haitian; Haitian Creole ❑ Hebrew ❑ Hindi ❑ Italian ❑ Japanese ❑ Korean ❑ Polish ❑ Portuguese ❑ Russian

**Ethnicity**: ❑ Not Hispanic ❑ Unknown Ethnicity ❑ Latino or Hispanic

## Spouse Information

Name: ________________________ Soc Sec#: ____ - ____ - ____ Date of Birth: ________
Employer: ______________________________________ Business Ph#: ____________________
Employer's Address: ___________________ City: ________ State: ______ Zip: ________

## Telephone Consumer Protection Act (TCPA) Consent Form

You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact may include sending an email or a text message and/or using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that Kunesh Eye Center, Inc. or any entity authorized by Kunesh Eye Center, Inc. may contact me as described above.

Signature: _________________________ Date: ______________

**Patient Name:** ______________________ **Date of Birth:** ______________

**Please print**

**Insurance Information**

| | | | |
|---|---|---|---|
| Primary (1st) Insurance | ______________________ | | |
| Policy # | ______________ | Group name and # | ______________ |
| Secondary (2nd) Insurance | ______________________ | | |
| Policy # | ______________ | Group name and # | ______________ |

**AUTHORIZATION FOR BILLING OF PROFESSIONAL SERVICES PROVIDED BY: KUNESH EYE CENTER, INC.**

## MEDICARE AUTHORIZATION TO RELEASE INFORMATION AND TO CLAIM PAYMENT

I request that payment of authorized Medicare benefits be made on my behalf to Kunesh Eye Center, Inc., for services furnished me by Kunesh Eye Center, Inc. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Kunesh Eye Center, Inc. accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. I understand that coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

Signature ______________________ Date ______________________

## MEDIGAP AUTHORIZATION TO RELEASE INFORMATION AND TO CLAIM PAYMENT

I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Kunesh Eye Center, Inc., if possible, or otherwise to me.

Signature ______________ Date ______________________

## INSURANCE AUTHORIZATION TO RELEASE INFORMATION AND TO CLAIM PAYMENT

I permanently authorize any holder of medical and other information about me to release that information to my insurance company. A photocopy of my signature may be used to file for insurance benefits. I also request the payment of benefits be made on my behalf to me or the above-mentioned provider who may accept assignment.

Signature ______________ Date ______________________