20200

Kozol Vision Center

20 Roche Bros Way Suite 7

North Easton MA 02356

Phone: 508-238-5200 Fax: 508-238-5146

Name of Patient: _____

Last *First* *Middle Initial*

Social Security #: _____ **Home Telephone #: (_____)**_____

Address: _____ **Apt. #:**_____

City: _____ **State**: _____ **Zip**: _____

Emergency Contact:_____ Relationship: _____Phone #:(_____)-_____

Your Date of Birth:_____ **Sex: ❑ M ❑ F** **Marital Status:** _____

Are you a full-time student? ❑ Yes ❑ No Cell Phone: _____E-Mail :_____

How did you learn of Kozol Vision Center _____

Home address, if different from above:_____

City:_____ State: _____ Zip: _____Phone #:(_____)-_____

Employer Name:

Address: _____

City:_____ State: _____ Zip:_____

Business Tel#: (_____)-_____-_____ Ext:._____ **Is today's visit required for employment?:** ❑ Yes ❑ No

INSURANCE INFORMATION

1. **PRIMARY INSURANCE**
Name of Insurance Co.:
Policy #:
Relationship to Subscriber: (Check one) ❑ Self ❑ Spouse ❑ Child ❑ Other:
Subscriber Name, DOB, & employer if different from self:

Is this visit related to a Workers Compensation, Motor Vehicle, or Personal Injury Accident? ❑ Yes ❑ No If yes, please see receptionist for additional information.

Primary Care Physician:_____

Location: _____ **Phone #: (____)**_____

Medical Information and Payment Authorization

I request that payment of authorized medical benefits be made on my behalf to Kozo! Vision Center, Inc. For services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or any other insurer, any information needed to determine these benefits payable for related services. A copy or system generated printout of this release will be as valid as the original form.

Although I have indicated that I am covered by the above health insures(s), I acknowledge and *agree* that I am personally responsible for *any* co-payments and/or deductibles associated with the services I receive which are not covered by my insurance and that I will be personally liable for all charges associated with the services I receive. If for any reason it is determined that my insurance is not obligated to pay for said services or that I am in fact not covered by the insurance identified above all charges associated with the services I receive. If for any reason it is determined that my insurance is not obligated to pay for said services or that I am in fact not covered by the insurance identified above.

Signature of Patient:_____ **Date:**_____