

**Korver Eyecare Center  
Welcome to Our Office**

**TELL US A LITTLE BIT ABOUT YOURSELF...**

Name _____	Today's Date _____
Address _____ _____	Date of Birth _____
City/State/Zip _____	Male _____ Female _____
Home Phone No. _____	S.S.N. _____
Daytime No. _____	Marital Status:    S    M    D    W
Cell Phone No. _____	Employment Status:    FT    PT    Other
Email Address _____	Employer _____
	Occupation _____
How did you hear about us:    Family/Friend    Yellow Pages    Insurance    Newspaper    Other	

**If the patient is a child:**

Parent's Name \_\_\_\_\_ Parent's Address \_\_\_\_\_

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**Primary Insurance – Please Present Insurance Card**

**Note:** Most insurance policies pay only a portion of your total charges. If you have questions about your Coverage, please contact your representative. We do not guarantee the accuracy of benefit Information given to us by insurance companies!!! **Please understand that financial responsibility For your account is yours, not your insurance company's.** I authorize the release of any medical or Other information necessary to process insurance claims. I authorize payment of medical benefits to The doctor.

**Signed:** \_\_\_\_\_ Date: \_\_\_\_\_

Insurance Company \_\_\_\_\_ I.D. # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Birthdate \_\_\_\_\_

Insured's Address \_\_\_\_\_

(City, State, Zip) \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Patient Relationship to Insured:

Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Full Time Student \_\_\_\_\_

**Payment is due when services are rendered or materials ordered.**

