

CORNEAL CONSULTANTS OF COLORADO, P.C.

PATIENT INFORMATION

Date: _____

PATIENT NAME _____ Home Phone (____) _____
Last First Middle

Address _____ Work Phone (____) _____

City _____ State _____ Zip Code _____ Occupation _____

Employer _____ Work Address _____

Sex M F Birth Date _____ Age _____ Marital Status S W M D Sep

Social Security Number _____ Spouse's Name _____

INSURED'S INFORMATION (Spouse, Parent, Etc.) If patient, mark "SAME"

Name _____ Social Security Number _____
Last First Middle

Address _____ Home Phone Number (____) _____

City _____ State _____ Zip Code _____ DOB _____

Employer _____ Work Phone Number (____) _____

Employer Address _____

INSURANCE INFORMATION

Medical Insurance? Y N Company _____ ID # _____ Group # _____

Medicare? Y N Medicare No. _____

Medicaid? Y N Medicaid No. _____ State ID _____ County _____ Category _____

Vision Insurance? Y N Company & ID _____

Do you have additional Medical Insurance with another Employer or Family Member? If yes, name of insured and insurance company or organization providing benefits _____

WORKMEN'S COMPENSATION On the Job injury? Y N If yes, Date of Injury _____

Employer _____ Phone# _____ Ins Carrier _____ Claim# _____

OTHER INFORMATION

Referred By _____ Phone _____

Address _____ City _____ State _____ Zip Code _____

Nearest Relative (NOT in your household)

Name _____ Phone _____

Address _____ City _____ State _____ Zip Code _____

I hereby authorize Doctors Damiano and Forstot to furnish information to the above insurance carrier concerning my illness and treatment. I further authorize payment of medical benefits to Doctors Damiano and/or Forstot.

You are responsible for your bill. We anticipate regular payments even though an insurance claim or legal suit is pending. We will furnish you with an insurance statement along with instructions and suggestions on how to file your health insurance claim.

The above information is complete to the best of my knowledge and I understand that I am financially responsible for this account.

Patient's Signature _____ Date _____

Insured's Signature _____ Date _____