Bluffs Vision Care, P.C.

Jacob J. Krieg, O.D. Jon M. Darnell, O.D.

PATIENT REGISTRATION

Date_____

Last Name:_____ First:_____ MI:____ Suffix:_____ Birthday:___/___/___

Address:_____ City:_____ State:_____ Zip:_____

Day Phone: ( )_____ Home Phone: ( )_____

Social Security No:_____ Sex: _____ Age:_____ Marital Status:_____

EMPLOYER INFORMATION

Employer:_____ Employer Phone: ( )_____

Employer Address:_____ City:_____ State:____ Zip:_____

Position:_____

RESPONSIBLE PARTY, IF OTHER THAN PATIENT:

Last Name:_____ First:_____ MI:____ Suffix:_____ Birthday:___/___/___

Address:_____ City:_____ State:_____ Zip:_____

Day Phone: ( )_____ Home Phone: ( )_____

Social Security No:_____ Sex: _____ Age:_____ Marital Status:_____

Employer:_____ Employer Phone: ( )_____

Employer Address:_____ City:_____ State:____ Zip:_____

INSURANCE INFORMATION (PRIMARY)

Insurance Company:_____ Address:_____

Policy Holder:_____ Group #_____ ID #_____

INSURANCE INFORMATION (SECONDARY)

Insurance Company:_____ Address:_____

Policy Holder:_____ Group #_____ ID #_____

I authorize the release of information for the purpose of providing care/treatment for myself and for the purpose of processing my claim/billing. I assign to Dr. Krieg/Dr. Darnell payment for their services that are available under any government plan, insurance policy, Worker's Compensation claim and any other benefit program.

Signature of Patient/Legal Guardian

_____

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