KARL B. CZIRR, O.D.
4309 W. 27TH PLACE, SUITE 102
KENNEWICK, WA 99338

Canyon View FAMILY EYE CARE

PATIENT INFORMATION

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Sex: ☐M ☐F Age _____ SSN _____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient Employed by _____ Occupation _____

Home Phone _____ Other Phone _____

WHAT IS YOUR MAIN REASON FOR THIS VISIT? _____

CONDITIONS Check (√) any conditions you have.

☐ Blurred Vision	☐ Seeing Flashes/Floaters	☐ Eye Surgery	☐ Cancer
☐ Double Vision	☐ Sore/Tired Eyes	☐ High Blood Pressure	☐ Stroke
☐ Discharge from Eyes	☐ Sensitivity to Light	☐ Diabetes	☐ Arthritis
☐ Headaches	☐ Wear Contact Lenses	☐ Blindness (RT or LT)	☐ Asthma
☐ Dry Eyes	☐ Discharge from Eyes	☐ Macular Degeneration	☐ Thyroid Problems

Check (√) If your blood relatives have had any of the following:

	Disease	Relationship to you
	Blindness	
	Macular Degeneration	
	Diabetes	
	Glaucoma	

LIST YOUR ALLERGIES to medications or substances

YOUR MEDS: Only current ones

INSURANCE INFORMATION

Due to the complexity of billing insurances, we will be unable to bill your insurance if you do not have complete information at the time service is rendered or products are ordered. In addition, we are no longer able to bill insurances that are Secondary to Medicare.

Primary Medical Insurance _____ **Vision Insurance** _____

Do you participate in a flex spending account? ☐ Yes ☐ No

PRIVATE INSURANCE and/or MEDICARE AUTHORIZATION

I, the undersigned, certify that I (or my dependent) have insurance coverage with (Ins. name)_____ and assign directly to Dr. Karl B. Czirr, O.D., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature Date

MEDICARE ONLY—MEDICARE ONLY—MEDICARE ONLY—MEDICARE ONLY—MEDICARE ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Karl B, Czirr, O.D., for any services furnished me by that doctor. I authorize any holder or medical information about me to release to the Health Care Financing Administration 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 authorize 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 or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Refraction is never a covered service by Medicare. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature Date