

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



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.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Seeing Flashes/Floaters | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Sore/Tired Eyes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Sensitivity to Light | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Wear Contact Lenses | <input type="checkbox"/> Blindness (RT or LT) | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Discharge from Eyes | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Thyroid Problems |

Check (✓) If your blood relatives had any of the following:		LIST YOUR ALLERGIES to medications or substances
Disease	Relationship to you	
Blindness		
Macular Degeneration		YOUR MEDS: Only current ones
Diabetes		
Glaucoma		

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 _____
Name of Insurance Co.

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. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature Date