Information entered_____
Account #_____

Ozog Eye Care and Laser Center

Mark F. Ozog, M.D.

Patient Information

Patient Name_____ SS #_____

Street_____

City_____State_____Zip_____

Home Phone_____Cell phone_____ Work Phone_____

Email address _____ Birth Date:_____ Married/Single/Divorced/Widowed

Employer_____Occupation_____

Medicare ____ Medicaid_____Prime Ins_____**(Present all insurance cards including military ID)**

2nd Ins_____ Insured name_____ Relationship_____

Insured Date Of Birth_____ SS# _____ Circle One: **Male/Female**

Who referred you to our office? _____FamilyPhysician_____

Is your visit a work related accident? _____ If yes, date of injury_____
Claim Number? _____

Name of Parent/Spouse _____Their employer_____

Name of closest friend or relative (outside of household)_____

Relationship_____ Phone _____

I understand that Medicare or other insurance will not pay for certain procedures (e.g. refraction, various other office procedures), and I will be responsible for the portion that Medicare and/or insurance does not pay. I also understand it is my responsibility to check that Ozog Eye Care & Laser Center is a provider under my insurance policy and I will be responsible for charges incurred. *I authorize the release of any medical information necessary to process insurance claims and request payment of benefits to Ozog Eye Care Center.*

I have been given the opportunity to read the patient privacy notice and receive a copy if I so choose.

Signed_____ Date_____