ADD ☐ CHG ☐ DEL ☐

ACCOUNT #	REFERRING PHYSICIAN	REFERRING PHYSICIAN #

4235 Indian Ripple Rd.
Suite 100
Dayton, OH 45440

Brian R. Stahl, O.D., M.D.
James R. Knowles, M.P.H., M.D.
Kelley Basinger, O.D.

DEAR PATIENT: Please assist us by *clearly* and correctly completing the information in the outlined areas. *Do NOT write or mark in shaded areas.*
Please give your insurance card(s) to the receptionist for copying.

PATIENT

FIRST NAME	MIDDLE INITIAL	LAST NAME	PATIENT'S EMAIL ADDRESS

PATIENT'S SEX	AGE	BIRTHDATE	SOCIAL SECURITY #	RACE	MARITAL STATUS	EMPLOYMENT
☐ 1 MALE ☐ 2 FEMALE		– –	– –	☐ CAUC. ☐ AFR. AMER. ☐ HISP ☐ ASIAN ☐ OTHER	☐ SIN ☐ MAR ☐ SEP ☐ DIV ☐ WID	☐ FULL ☐ PART ☐ RET ☐ UNEM

STREET ADDRESS	CITY	STATE	ZIP CODE

HOME TELEPHONE NUMBER / CELL	EMERGENCY CONTACT TELEPHONE NUMBER	EMPLOYER'S NAME & PHONE NUMBER
( ) –	( ) –	

BILL TO

FIRST NAME (If different than patient)	MIDDLE INITIAL	LAST NAME (If different than patient)	MAIL CODE	ACCT. TYPE

STREET ADDRESS (If different than patient)	CITY (If different than patient)	STATE	ZIP CODE

PRIMARY COVERAGE

CARRIER CD. NO.	PRIMARY INSURANCE CO. NAME & ADDRESS (IF NO CARD COPY AVAILABLE)

EMPLOYER	PRIMARY INSURANCE CO. CERTIFICATE OR CONTRACT #	INSURANCE GROUP NO. OF EMPLOYER

SOCIAL SECURITY NO. OF POLICY OWNER	BIRTHDATE	PATIENT RELATIONSHIP TO INSURED
– –	– –	SELF ☐ 0 SPOUSE ☐ 3 SON ☐ 4 DAUGHTER ☐ 5 OTHER ☐ 6 DISABLE ☐ 7

POLICY HOLDER NAME

SECONDARY COVERAGE

CARRIER CD NO.	SECONDARY INSURANCE CO. NAME & ADDRESS (IF NO CARD COPY AVAILABLE)

EMPLOYER	SECONDARY INSURANCE CO. CERTIFICATE / CONTRACT #	INSURANCE GROUP NO. OF EMPLOYER

SOCIAL SECURITY NO. OF POLICY OWNER	BIRTHDATE	PATIENT RELATIONSHIP TO INSURED
– –	– –	SELF ☐ 0 SPOUSE ☐ 3 SON ☐ 4 DAUGHTER ☐ 5 OTHER ☐ 6 DISABLE ☐ 7

POLICY HOLDER NAME

AUTHORIZATION

THE ABOVE SUBSCRIBER HEREBY AUTHORIZES HIS/HER INSURANCE COMPANY TO ISSUE INDEMNITY CHECKS TO THE ABOVE LISTED MEDICAL PROVIDER FOR SERVICES PROVIDED.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician OR organization furnishing the services and authorize such physician OR organization to submit a claim to my insurance carrier OR Medicare for payment. I authorize any holder of medical or other information about me to release to insurance carriers OR the Health Care Financing Administration and its agents OR the Social Security Administration or its intermediaries OR any agency, group or person(s) necessary to secure payment any information needed for this or related Medicare claim. * For and in consideration of services rendered and to be rendered by the above listed medical provider, I hereby guarantee payment of all charges incurred for this account. * The patient and his / her representative recognizing the need for health care, consents to the above listed medical provider rendering services as ordered by the physicians, including medical or surgical treatment, laboratory procedures, X-ray examinations or other services rendered under the general and specific instructions of the physicians. * I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

DATE ______________________ SIGNATURE X ______________________
PATIENT (PARENT/GUARDIAN IF MINOR)