BERG·FEINFIELD
VISION CORRECTION

Talia Kolin, M.D.
Pediatric Ophthalmology and Strabismus

Today's Date: _____

PATIENT INFORMATION:

Name: _____ Eye Color_____Sex_____

Address _____ Birthdate _____/_____/_____Age _____

City, State, Zip _____ PATIENT'S INSURANCE _____

Home #( )_____ Social Security # _____

Work #( )_____ Med-Cal # _____

Referred BY: _____ Patient's Physician_____

RESPONSIBLE PARTY: **SPOUSE:**

Name: _____ Name: _____

Address (if different) _____ Address (if different) _____

City, State, Zip _____ City, State, Zip _____

Birthdate _____/_____/_____ Birthdate _____/_____/_____

Social Security_____ Social Security_____

Driver's License_____ Driver's License_____

EMPLOYER _____ EMPLOYER _____

Address _____ Address _____

City, State, Zip_____ City, State, Zip_____

Phone ( )_____ Phone ( )_____

INSURANCE _____ INSURANCE _____

Group _____ Group _____

Policy # _____ Policy # _____

Nearest relative or Friend (For Emergency Use):

Name: _____ Phone ( )_____

At this office we require you to pay for services at the time of visit. If you have made other arrangements, please remember you are ultimately, responsible for payment. Please show your insurance card to our receptionist and Initial one of the methods of payment below:

How will you be paying for today's visit? ☐ **Cash** ☐ **Check** ☐ **HMO** ☐ **MediCal** ☐ **Other:**_____

HEALTH INFORMATION:

1. What is the patient's eye problem? _____
2. Please describe any past eye problems _____
   _____
3. Does the patient wear glasses? _____
4. Does the patient have any medical problems? _____If yes explain_____
   _____
5. List medications patient is currently taking:_____
6. Please list any allergies the patient may have_____
7. Do any members of the family have any eye problems (which members and what problems)_____
   _____
8. Which members of the immediate family wear glasses?_____
9. Are there any members of the family with significant medical problems such as diabetes or hypertension?
   _____

BILLING INFORMATION

NON-INSURED PATIENTS:

If you are not insured, it is our office policy here at **Berg•Feinfield Vision Correction** that payment is due at the time services are rendered unless a prior payment arrangement has been made.

I understand that I am financially responsible for payment of all charges incurred for services received from the doctor's office.

_____ _____

Signature of Patient/Guardian if Minor Date

INSURED PATIENTS:

I, the undersigned certify that I (or my dependent) have insurance coverage with:

_____

Name of Insurance Company (ies)

I assign directly **Berg•Feinfield Vision Correction** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible of all charges incurred for services received from the doctor's office whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Submit