



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.