Welcome to Our Office

Welcome to Koziol-Thoms Eye Associates, S.C. Thank you for choosing us for your eye care needs.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name ____ MI ____ Last Name ____ Preferred Name ____

Street Address ____ City ____ State ____ Zip ____

Social Security Number ____ Date of Birth ____ Home Phone ____ Alternate Phone ____

Email Address ____ Guardian ____ Person Responsible for Account ____

May we send you E-Mail? Y N

Emergency Contact ____ Emergency Phone ____

Primary Care Physician

Primary Care First Name ____ Primary Care Last Name ____

Address of Primary Care Physician ____ City ____ State ____ Zip ____ Phone ____

Referring Physician

Referring Physician First Name ____ Referring Physician Last Name ____

Address of Referring Physician ____ City ____ State ____ Zip ____ Phone ____

Race

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Declined to Specify
☐ Other

Ethnicity

☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined to Specify

Preferred Language

☐ English ☐ Spanish ☐ Chinese
☐ Dutch ☐ French ☐ German
☐ Hindi ☐ Indonesian ☐ Other

Height ____ ft ____ in Weight ____ lbs

Do you smoke? ☐ Yes ☐ No

If yes, how much/often? ☐ Occasional ☐ ½ pack/day ☐ 1 pack/day ☐ 1+ pack/day

Pharmacy Name and Address: ____

Please provide your insurance cards for us to copy.

In order to control the cost of billing, we ask that any patient portion be paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing cost than be forced to raise our fees. All professional services and materials are charged to the patient. The undersigned is ultimately responsible for any bill in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to **Koziol-Thoms Eye Associates**. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature ____ Date ____