



1015 West View Park Drive
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Karlik Ophthalmology

PATIENT INFORMATION

Name _____ Date _____
(last) (first) (middle)
Address _____ Male Female
_____ Single Married Divorced Widowed
_____ (city) (state) (zip)

Social Security # _____ Birthdate _____
Occupation _____ Employer Name _____
Home Phone _____ Work Phone _____
If Work Related, Date of Injury _____ Cell Phone _____
Emergency Contact Person/Phone Number _____ / _____

Name of Insurance _____
Name on the Card _____ Relationship to PolicyHolder _____

If Policy Holder is not Self:

Name of Policy Holder _____
Birthdate of Policy Holder _____
SS # of Policy Holder _____
Address and Phone Number of Policy Holder (if different than yours):

ASSIGNMENT OF BENEFITS:

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT.

SIGNED _____ DATE _____

