Welcome to Our office

Stephen M. Kelly, OD

Patient Information

Date:_____

Name:_____ M F DOB:_____
Last First MI

Cell#:_____ Home#:_____ Work#:_____

Address:_____

City:_____ State:_____ Zip:_____

Email:_____ Occupation:_____

By giving my E-mail address I authorize Dr. Stephen Kelly notify me of upcoming appointments and events. I understand my information will be kept confidential and will not be sold to any outside parties.

Emergency contact:_____

Phone #:_____ Relationship to you:_____

How were you referred to our office?_____

Last Eye Exam:_____ Last Medical Exam:_____ PCP:_____

Vision Insurance

Primary **Vision** plan:_____ Secondary **Vision** plan:_____

ID#:_____ ID#:_____

Subscriber's name:_____ Subscriber's name:_____

Subscriber's DOB:_____ Subscriber's DOB:_____

Subscriber's relationship to you:_____ Subscriber's relationship to you:_____

Medical Insurance

Primary **Medical** plan:_____ Secondary **Medical** plan:_____

□PPO or □HMO ID#:_____ □PPO or □HMO ID#:_____

Subscriber's name:_____ Subscriber's name:_____

Subscriber's DOB:_____ Subscriber's DOB:_____

Subscriber's relationship to you:_____ Subscriber's relationship to you:_____

Financial Responsibility

I authorize Stephen M. Kelly, OD to release any information necessary to receive payment from my insurance company. I also authorize my insurance benefits to be paid directly to Stephen M. Kelly, OD. I understand I am responsible for any non-covered or unpaid services. I permit a copy of this authorization to be used in place of the original.

Signature:_____ Date:_____

Acknowledgement of Notice of Privacy Practices

I have received and understand Dr. Kelly's Notice of Privacy Practices. I am aware that a copy will be available at the front desk and offered to me at each appointment.

Signature:_____ Date:_____

Print Name:_____