KING EYE ASSOCIATES

7252 Frankford Ave Philadelphia, PA 19135 – (215) 335-3555

Date_____

Welcome to King Eye Associates.
Please take the time to read and complete this patient registration form.

PERSONAL INFORMATION

Full Name (First, Last)_____ Date of Birth_____ Sex M F

Address_____ Social Security Number_____

City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____

E-mail_____

VISION INSURANCE INFORMATION

Company Name_____

Policy Holder's Information

ID Number_____

Full Name (First, Last)_____

Date of Birth_____

Social Security Number_____

Relationship to Patient_____

MEDICAL INSURANCE INFORMATION

Company Name_____

Policy Holder's Information

ID Number_____

Full Name (First, Last)_____

Date of Birth_____

Social Security Number_____

Relationship to Patient_____

****ALL CO-PAYMENTS MUST BE PAID THE DAY OF YOUR APPOINTMENT****

PRIMARY HEALTH CARE PROVIDER INFORMATION

Name_____ Phone Number_____

Address_____ City_____ State_____ Zip Code_____

Please check the reason for your visit today:

- ☐ Eyeglasses
- ☐ Contact Lenses
- ☐ Medical Problem

****Please note that most insurance companies do not cover the fitting and evaluation of contact lenses.****
Fees for these services will be the responsibility of the patient.

I authorize payment of all insurance benefits for services rendered by this office be made payable on my behalf to King Eye Associates or Sheeba Bhaskaran, O.D. I hereby authorize this office to release to the Health Care Financing Administration or other Insurer any information necessary to determine the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand I am responsible for all charges not covered by insurance benefits.

Patient's Signature (Parent or Guardian if Minor)_____ Date_____