

Associated Ophthalmologists
Dr. David Morimoto Dr. Aras Zlioba
219 N. Hammes Ave.
Joliet, Illinois 60435

Patient Name: _____ Account # _____
Address: _____
City, State, Zip _____
Date of Birth: _____ Marital Status: M S D W Spouse _____
Gender: Male/Female Social Security # ____ - ____ - ____

Home Phone #: _____ Work Phone #: _____ Cell Phone # _____
Employer Name: _____
Emergency Contact: _____ Relation to Patient _____
Emergency Phone: _____

Patient Email Address: _____

Previous Eye Surgery? Yes No (if yes explain) _____ Date: _____
Primary Care Physician: _____
Pharmacy Name: _____ Location: _____
List any known allergies _____
Is your visit for today work related? Yes ____ No ____

Primary Ins: _____ Phone : _____
Insurance Address _____
Insured Name: _____ Relation to Patient _____
Policy # _____ Group # _____

Secondary Ins: _____ Phone: _____
Insurance Name: _____ Address: _____
Policy # _____ Group # _____

CHECK IN NOTE:

Copays, Refractions, deductibles and balances are due on the day of services. As part of our service we will submit your insurance claims.

Insurance/Financial arrangements should be made with our Insurance/Billing Department prior to any services.

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS DECLARATION

I hereby authorize release of any medical information necessary to process claims and also ASSIGN to the DOCTOR all payments from all insurance companies for services rendered. I understand and agree to the above conditions.

SIGNATURE

DATE