

COLORADO EYE CARE

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WELCOME TO OUR OFFICE

PLEASE PRINT AND COMPLETE ALL INFORMATION BELOW

Patient's Name: _____ Date: _____

Home Address: _____ Nick Name _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Please contact us immediately upon a change in any demographic information to allow excellent communication with our office.

Preferred Salutation: MR. MRS. MS. MISS DR. Other: _____ Gender: M F Age _____

Date of Birth: _____ Name of Spouse/Parent: _____

Social Security #: _____

Occupation: _____ Employer: _____

Email address: _____ May we contact you by email? _____

Emergency Contact Name: _____ Contact Phone: (____) _____

Who may we thank for referring you to us? _____

Name of person responsible for payment: _____

Primary Insurance Company: _____ Insured: _____

Policy #: _____ Group #: _____

Secondary Insurance Company: _____ Insured: _____

Policy #: _____ Group #: _____

Primary Care Physician: _____ **Other Physician** _____

Telephone/City: _____ Telephone/City: _____

In an effort to ensure coordination of care we will be sending a summary of your examination to your Primary Care Physician for certain medical diagnoses.

CONSENT FOR THE RELEASE OF HEALTH & BILLING INFORMATION

I give my permission for the following persons to speak with Colorado Eye Care regarding my Information:

(CIRCLE HEALTH BILLING OR BOTH)

1) _____ Relationship: _____ HEALTH BILLING BOTH

2) _____ Relationship: _____ HEALTH BILLING BOTH

3) _____ Relationship: _____ HEALTH BILLING BOTH

PLEASE READ THE FOLLOWING AND SIGN BELOW

I authorize insurance payment of medical benefits to Colorado Eye Care for all services. I authorize the release of any medical or other information necessary to process this claim. I authorize the release of medical or other information to other health care providers when requested. I also request payment of government benefits to Colorado Eye Care on my behalf. **Patients will be responsible for all charges not covered by their insurance company (see our Financial Policy for details).**

Payment Methods: Cash, Personal Check, Money Order, MasterCard™, Visa™, Discover

Patient or Responsible Party Signature

Date