Ophthalmology Consultants The Center for LASIK
Specialists in cataract and laser surgery
Eye plastics and reconstructive surgery
Corneal and refractive surgery
www.bestvision.com

Randy Burks, M.D., F.A.C.S.
Ray Gailitis, M.D., F.A.C.S.

NEW PATIENT INFORMATION

Welcome to our office. Please complete this form and return it to the receptionist, who will use the information to prepare your medical record. **PLEASE PRINT**

Date _____

Name _____ Birthdate _____ Age _____ Sex: M F
First Middle Last Mo. Day Yr.

Mailing Address _____ Phone (_____) _____
Include apt. # or box # City State Zip

e-mail _____ Cell Phone (_____) _____

Temporary Address _____ Phone (_____) _____
Include apt. # or box # City State Zip

Employer _____ Work Phone (_____) _____

Soc. Sec. # _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Spouse's Name _____ Employer _____ Work Phone (_____) _____

Emergency Contact: Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

Who recommended us? _____
Name

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Insurance Information

Please identify your health insurance carrier. ☐ I do not have insurance coverage.

☐ Medicare # _____ ☐ Medicaid #

_____

☐ Medicare Supplement (if applicable) _____ Policy #

_____

☐ Blue Cross/Blue Shield #

_____

☐ Workers Compensation (job injury): ☐ Yes ☐ No If yes, to whom is bill to be sent? _____

☐ Other Insurance _____ Policy #

_____

Policy Holder's Name (if other than patient) _____Birthdate_____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other _____
Please Specify

Authorization to Release

I request that payment of authorized Medicare / insurance benefits be made on my behalf to Randy Burks, M.D., F.A.C.S.; Ray Gailitis, M.D., F.A.C.S., or Ophthalmology Consultants for services rendered to me by the same.

I authorize any holder of medical records, or other information about me, to release to my insurance company or the Health Care Financial Administration and its agents any information needed to determine these benefits for related services.

Signature (Patient, or parent if minor) _____