

**Low Vision  
Services Of Kentucky**

Suite 501 • 120 North Eagle Creek Drive • Lexington, Kentucky 40509  
(859)977-1129 • (800)627-2020 • Facsimile (859)263-3757

**PATIENT INFORMATION FORM**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_

( ) Single      ( ) Married      ( ) Separated      ( ) Divorced      ( ) Widowed

Spouse's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ BusinessPhone: \_\_\_\_\_ Cell: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_

Name of nearest relative, friend/neighbor: \_\_\_\_\_

Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

If student, give name of School Board District: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Person responsible for bill: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Where employed: \_\_\_\_\_ Occupation: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

Reason for seeking low vision service: Statement \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Statement provided ( ) by patient: ( ) by applicant on behalf of patient \_\_\_\_\_

How did you first learn of this organization? ( ) Family ( ) Friend ( ) Physician ( ) Hospital  
( ) Community agency ( ) Educational facility ( ) Yellow Pages ( ) Other \_\_\_\_\_

(Over)

**MEDICAL INSURANCE (Numbers Please):**

Blue Cross/Blue Shield: \_\_\_\_\_ Medicaid: \_\_\_\_\_

Medicare: \_\_\_\_\_ Other: \_\_\_\_\_

**PATIENT'S AUTHORIZATION** to release medical information and claim payment information:

I hereby authorize the above physician(s) to release any information regarding services rendered by him and allow a photocopy of my signature to be used to file insurance.

Date: \_\_\_\_\_ Patient: \_\_\_\_\_  
(parent or Guardian If Minor)

I hereby authorize and direct my insurer to issue payment check(s) for the benefits due me for the services rendered by the above-named physician(s) to be made directly to him regardless of my insurance benefits, if any. I understand I am financially responsible for the fees for services rendered.

Date: \_\_\_\_\_ Responsible person policy owner insured: \_\_\_\_\_

**STATEMENT** to permit payment of Medicare benefits to Provider, Physician and Patient: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request the payment of authorized benefits by made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the service or authorize such physician or organization to submit a claim to Medicare for payment to me. I request that payment under the Medical Insurance Program be made either to me or the above-named Physician(s).

Date: \_\_\_\_\_ X \_\_\_\_\_