Patient Registration Form

Robert A. Kolarczyk, M.D.
Ophthalmology

Patient Information

Patient Information

Last Name:	First Name:	M.I.	Nickname	☐Mr ☐Dr ☐Mrs ☐Ms

Mailing Address:

City/State/Zip:

Preferred Phone: ☐ Home ☐ Cell ☐ Work ☐Other	Preferred Communication: ☐Phone or ☐Email Confirm Appointment by: ☐Phone or ☐Email

Home Phone: ( )	Cell Phone: ( )	Work Phone: ( ) Ext.	Emergency Phone: ( )

Date of Birth: / /	Sex: ☐ M ☐F	Social Security #:	Driver's License #	Patient Email:

Primary Language:	Race: ☐Caucasian ☐Asian ☐American Indian ☐African American ☐Pacific Islander ☐Other ☐Declined	Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Declined

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed	Spouse's Name:	Spouse's Date of Birth

Emergency Contact Name and Address:	Relationship to Patient

Emergency Email Address: @ .____	Spouse's Employer

Additional Information

Additional Information

Primary Physician's Name: M.D.	Preferred Pharmacies (Can list multiple pharmacies) Retail Pharmacy: Location Mail Order:

How did you hear about Dr. Kolarczyk?

Employment Information:

☐ Employed ☐ Self-Employed ☐ Retired ☐ Full-Time Student	Employer:	Occupation: / Work Title

Person responsible for bill (ONLY IF DIFFERENT THAN PATIENT)

Name:	Address:	Phone: ( )
Relationship:	City/State/Zip:	

I authorize release of information necessary to process insurance and/or Medicare claims on my behalf. I also agree to pay any co pays at time of service and any balance per my insurance statement. I understand that payment is my responsibility regardless of insurance coverage. If I do not have any insurance or have an HMO insurance, I agree to pay at time services are rendered unless prior arrangements are made with our office.

Signature of Patient or Guardian: ________________________ Date: __________

Printed Name of Patient or Guardian: ____________________________