

**ASSOCIATED OPHTHALMOLOGISTS**  
219 N HAMMES  
JOLIET, IL 60435-8145  
815/741-3220  
Dr. David Morimoto      Dr. Aras Zlioba

**NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **BIRTHDATE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP CODE:** \_\_\_\_\_

**GENDER:** M F      **SOCIAL SECURITY NUMBER:** \_\_\_\_\_

**HOME PHONE NUMBER:** \_\_\_\_\_ **CELL PHONE NUMBER:** \_\_\_\_\_

**EMERGENCY CONTACT NAME:** \_\_\_\_\_ **PHONE NUMBER:** \_\_\_\_\_

**RELATIONSHIP TO PATIENT:** \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_

**PRIMARY CARE PHYSICIAN:** \_\_\_\_\_

**PHARMACY AND LOCATION:** \_\_\_\_\_

**EMAIL ADDRESS:** \_\_\_\_\_  
(Our patient portal will allow you to securely access certain elements of your health information and test results)

IS YOUR VISIT FOR TODAY WORK RELATED? YES NO

**EMPLOYER NAME:** \_\_\_\_\_ **EMPLOYER PHONE NUMBER:** \_\_\_\_\_

**PREVIOUS EYE SURGERY:** YES NO (IF YES), WHICH SURGERY: \_\_\_\_\_ **DATE:** \_\_\_\_\_

**INSURANCE**

**GUARANTOR NAME:** \_\_\_\_\_ **GUARANTOR PHONE NUMBER:** \_\_\_\_\_

**PRIMARY INSURANCE:** \_\_\_\_\_

**INSURANCE ADDRESS:** \_\_\_\_\_

**POLICY HOLDER NAME:** \_\_\_\_\_ **POLICY HOLDER DATE OF BIRTH:** \_\_\_\_\_

**POLICY NUMBER:** \_\_\_\_\_ **GROUP NUMBER:** \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_

**INSURANCE ADDRESS:** \_\_\_\_\_

**POLICY HOLDER NAME:** \_\_\_\_\_ **POLICY HOLDER DATE OF BIRTH:** \_\_\_\_\_

**POLICY NUMBER:** \_\_\_\_\_ **GROUP NUMBER:** \_\_\_\_\_

**CHECK IN NOTE:**

Copays, Refractions, deductibles and balances are due on the day of service. 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 service.

**RELEASE OF INFORMATION AND ASSIGNMENTS OF BENEFITS DECLARATION**

I hereby authorize release of any medical information necessary to process my insurance claim 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