DR. ROBERT J. KISH
OPTOMETRIST

OPTICS UNLIMITED
748 LONG HILL ROAD
GROTON, CT 06340
860-448-3937

Welcome to our office. Please fill out these forms and return them, with your current insurance cards, to the receptionist.
(PLEASE PRINT)

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE- HOME: _____ CELL: _____ WORK: _____
EMAIL: _____ OCCUPATION: _____
DATE OF BIRTH: _____ AGE: _____ GENDER: _____

IF A NEW PATIENT, HOW DID YOU HEAR ABOUT OUR OFFICE?

_____

IN THE FUTURE, WOULD YOU BE INTERESTED IN ACCESSING OUR PATIENT PORTAL? _____

INSURANCE INFORMATION

PRIMARY	SECONDARY
INSURANCE COMPANY 1: _____	INSURANCE COMPANY 2: _____
INSURED'S NAME 1: _____	INSURED'S NAME 2: _____
INSURED'S DATE OF BIRTH 1: ____/____/____	INSURED'S DATE OF BIRTH 2: ____/____/____
INSURANCE ID# 1: _____	INSURANCE ID# 2: _____
INSURANCE GROUP # 1: _____	INSURANCE GROUP # 2: _____
INSURED'S EMPLOYER 1: _____	INSURED'S EMPOYER 2: _____
PATIENT RELATIONSHIP TO INSURED 1: _____	PATIENT RELATIONSHIP TO INSURED 2: _____

Privacy Policy/ Authorization To Release Information/ Assignment of Insurance Benefits
I have read and carefully reviewed the PRIVACY POLICY of this office, which describes how medical information about me may be used and disclosed and how to get access to this information. I may revoke this consent at any time. I give consent to this office to submit claims to my insurance company either electronically or with paper claims, for services rendered. Payment from insurance companies will be paid directly to this office. **I understand that I am responsible for any payment amount not covered by my insurance.**

Signature: _____ Date: _____