Julia D. Katz, M.D., PLLC
(212) 796-4334

572 Park Ave.
New York, NY 10065

WELCOME TO OUR OFFICE

LAST NAME: _____ FIRST: _____ MI: _____

Circle one:
GENDER: *male female* MARITAL STATUS: *single married divorced separated widowed*

DATE OF BIRTH (month/day/year): _____ / _____ / _____ Age: _____

HOME Address: _____ Apt # _____

City: _____ State: _____ ZIP: _____

TEL: HOME: (____) _____ WORK: (____) _____ CELL: (____) _____

OCCUPATION: _____ EMPLOYER: _____

WORK Address: _____ City: _____ State: _____

Reason for Visit: Routine Cataract LASIK Other: _____

Referred By:
_____

Internist: _____
Phone: (____) _____

Address: _____

Optometrist or Ophthalmologist: _____

Address: _____

PHARMACY: _____ Phone: (____) _____

Primary Insurance: _____ Insurance #: _____

Policy Holder Name: _____self spouse parent DOB ____ / ____ / ____

_____

Secondary Insurance: _____ Insurance #: _____

Policy Holder Name: _____ self spouse parent DOB _____ / _____ / _____

For patients with Health Insurance (Medicare or Other):

I request payment of authorized Medicare or other insurance carrier benefits be made on my behalf to Julia D. Katz, MD, PLLC for any services rendered to me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) or its intermediaries or carriers, or to the billing agent of Julia D. Katz, MD, PLLC, any information needed to determine these benefits or the benefits payable for related services. Furthermore, it is my understanding that, regardless of insurance coverage, payment for services rendered is my responsibility.

Signed: Date: _____