DR. CYNTHIA KIERNAN & ASSOCIATES
DOCTORS OF OPTOMETRY

Welcome to Our Office
702-614-5435

Monday, Wednesday, and Friday	9:00am - 6:00pm
Tuesday and Thursday	10:00am - 7:00pm
Saturday	9:00am - 5:00pm
Sunday	10:00am - 4:00pm

Closed for lunch daily 1:00pm to 2:00pm

Patient Information

LAST NAME:	ADDRESS: APT.#:
FIRST NAME: MIDDLE INITIAL:	CITY: STATE: ZIP:
SEX: F / M DATE OF BIRTH: AGE:	HOME #: WORK #:
SOCIAL SECURITY#:	EMAIL:
OCCUPATION:	

Parent/Guardian - Responsible Party

LAST NAME:	ADDRESS: APT.#:
FIRST NAME: MIDDLE INITIAL:	CITY: STATE: ZIP:
RELATIONSHIP TO PATIENT:	HOME #: WORK #:
SEX: F / M DATE OF BIRTH:	EMPLOYER:
SOCIAL SECURITY#:	

Insurance

VISION INSURANCE:	MEDICAL or SECONDARY INSURANCE:
POLICY HOLDER'S ID. #:	POLICY HOLDER'S ID. #:
POLICY HOLDER'S GROUP #:	POLICY HOLDER'S GROUP #:
POLICY HOLDER'S NAME:	POLICY HOLDER'S NAME:
POLICYHOLDER'S ADDRESS:	POLICYHOLDER'S ADDRESS:
CITY: STATE: ZIP:	CITY: STATE: ZIP:
POLICYHOLDER'S DATE OF BIRTH:	POLICYHOLDER'S DATE OF BIRTH:
POLICYHOLDER'S EMPLOYER:	POLICYHOLDER'S EMPLOYER:
POLICYHOLDER'S MARITAL STATUS: q MARRIED q SINGLE q DIVORCED q WIDOWED	POLICYHOLDER'S MARITAL STATUS: q MARRIED q SINGLE q DIVORCED q WIDOWED
RELATIONSHIP TO PATIENT:	RELATIONSHIP TO PATIENT:

Receipt of Notice of Privacy Written Acknowledgement Form

I have reviewed a copy of Cynthia Kiernan, O.D. & Associates' Notice of Privacy Practices (Green Form). _____***Initials***

Authorization

I authorize the doctor to release any information including the diagnosis and records of any treatment or examination rendered to me or my child to third party payers and/or practioners. I understand that filing of insurance claims is my responsibility and may be provided as a service to me by Cynthia Kiernan, O.D. and that any agreement for vision coverage is between the above insurance company and myself. Any estimate portion I may pay at the time of service is only an estimate portion according to expected coverage by my insurance company. I understand that my portion may be more if my insurance company does not pay the estimated amount. I understand that the services are rendered independent of insurance company reimbursement. I understand that I am personally responsible for payment of all fees for vision services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the doctor of any related attorneys and collection fees. Service charges of 1 1/2% per month will be added on all balances over 60 days past due.

I AUTHORIZE PAYMENT OF BENEFITS TO DR. KIERNAN. _____ ***(Please Initial)***

I certify that the given information is correct to the best of my knowledge.

Patient's Signature: (If patient is a minor, guardian must sign) Date:

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