

# Kitsap Eye Physicians

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## PATIENT INFORMATION

(Please Print)

Today's Date: \_\_\_\_\_ Social Security no.: \_\_\_\_\_  
Patient's name: \_\_\_\_\_ Marital status (circle one)  
Single / Mar / Div / Sep /  
Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ Widowed  
Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex:  M  F  
(Former name): \_\_\_\_\_  
Home phone no.: \_\_\_\_\_ Cell phone no.: \_\_\_\_\_  
Street address: \_\_\_\_\_ ( ) ( )  
P.O. box: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer phone no.: \_\_\_\_\_ ( )  
Who referred you to our clinic (please choose one) Dr. \_\_\_\_\_  Family  Friend  
 Other \_\_\_\_\_

Other family members seen here: \_\_\_\_\_

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: \_\_\_\_\_ Birth date: \_\_\_\_\_ Address (if different): \_\_\_\_\_ Home phone no.: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer address: \_\_\_\_\_ Employer phone no.: \_\_\_\_\_  
Is this patient covered by insurance?  Yes  No Patient's relationship to subscriber:  Self  Spouse  Child  Other  
 No Insurance  Medicare  KPS  NBN  Group Health  Aetna  
 DSHS  VSP  Regence/Premera  TriCare  Other \_\_\_\_\_  
Subscriber's name: \_\_\_\_\_ Subscriber's S.S. no.: \_\_\_\_\_ Birth date: \_\_\_\_\_ Group no.: \_\_\_\_\_ Policy no.: \_\_\_\_\_  
Patient's relationship to subscriber:  Self  Spouse  Child  Other  
Name of secondary insurance (if applicable): \_\_\_\_\_ Subscriber's name: \_\_\_\_\_ Group no.: \_\_\_\_\_ Policy no.: \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Kitsap Eye Physicians to release any information required to process my claims.

Patient/Guardian signature: \_\_\_\_\_

Date \_\_\_\_\_