www.nyvisiongroup.com

119-15 Atlantic Ave
Richmond Hill, NY 11418
Tel: (718) 805-0700
Fax: (718) 805-2269

37-39 Murray Street
New York, NY 10007
Tel: (212) 243-2300
Fax: (646) 370-1418

279 Wyckoff Avenue
Brooklyn, NY 11237
Tel: (718) 381-1632
Fax: (718) 381-3674

Personal Information (Please Write Clearly)

How did you hear about us? ☐ **Optical Store** ☐ **Medical Dr.** ☐ **TV** ☐ **Print Ad** ☐ **Friend** ☐ **Internet**

Name of Optical Store (if any): ____

Primary Medical Doctor: ______________________ **Doctor's Phone #: (   ) _____-_______________**

Pharmacy Name: _____________________________ **Pharmacy Phone #: (   ) _____-____________**

Pharmacy Address: ____

Patient Last Name: _____________________________ **First Name:**_____________________________

Patient Sex: ___**Male** ___**Female** **Date of Birth:** ____/_______/______

Social Security #: _______-___________-_______**Marital Status:**__**Single**__**Married**__**Widowed** __**Other**

Home Address: _______________________ **Apt #:**_______ **Mobile Phone #: (   )** _____ - _________

City: ____________________________ **State:** _________ **Zip Code:**______________

Home Phone #: (   ) _______-____________ **E-Mail Address:**_______________________________

Emergency Contact Name:__________________ **Emergency Contact #: (   )** ____ -______________

Relationship:____

Employer's Name: ____

Employer's Address: ____

City: ____________________________ **State:**__________ **Zip Code:**_____________

Work Phone #: (   )_______-___________ **Occupation:** __________________________________

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Insurance Information (Please Fill out all Information)

Name of Primary Insurance: ____

Name of Insured: ______________________ **ID #:** _________________ **Group #:** _____________

Insured Social Security #: _______-__________-__________ **Insured Date of Birth:** _____________

Name of Secondary Insurance (If Any): ______________________________________

Name of Insured: ___________________ **ID #:** _______________ **Group # :**_________________

Insured Social Security #: __________________ **Insured Date of Birth:** ______________________

Patient or Authorized Signature:

I authorize the release of any medical information necessary to process this claim and request payment of benefits to Harry Koster, M.D. PC (the "PC"). I understand that I am financially responsible for all fees and will be billed for any balance, deductible and co-payment which my insurance does not cover.

If I am a member of a managed care program, I am aware that it is my responsibility to provide the PC with an appropriate referral form. If the PC unable to collect from my insurance company because of my failure to provide it with an appropriate referral in a timely manner, I agree that I will be responsible to pay for these services personally.

I have received a copy of the Notice of Privacy Practices and I have been provided an opportunity to review it.

____ __________________
Signature **Date**

CONFIDENTIAL