Welcome to the Practice of:

Dr. Kenneth A. Lebow, Dr. Beth Baylor and Dr. Valerie Foytik

Today's Date:_____ Birthdate:_____

Patient's name_____Name preferred:_____

Address_____ City_____ State_____Zip_____

Home Phone_____ Work Phone_____ Cell # _____

Email address _____Social Sec. Number_____

In compliance with HIPPA, please contact me by:___phone, ___email, ___text, ____cell

INSURANCE :

Primary Insured Name:_____ Relationship to Patient:_____

Primary Insured Phone #_____ DOB_____

Primary Insured Social Security number:_____

Vision Plan Name & ID number: _____

Health Insurance Name & ID number:_____

Person responsible for payment:_____

Please return this form with a photo ID and your insurance cards, to the front desk. If we do not participate with your insurance (we will file a claim for your reimbursement), however full payment is expected at the time of service. For your convenience we accept "Care Credit". Please ask if you need assistance with your insurance or account.

I understand that if my account is referred for collection a 33.3% surcharge will be added.

Signature of Patient/Parent/Guardian:_____