

Staten Island Ophthalmology (SIO)
Academic Eye Center (AEC)
John S. Kung, MD, FAAO, FICS

Last Name: _____ First Name: _____ MI: _____
Social Security #: _____ Date Of Birth: _____
Patient Home Tel: _____ Sex: _____ Marital Status: _____
Address: _____
City: _____ State: _____ Zip: _____
Emergency Contact: _____ Tel# _____
Referring Physician: _____ Tel#: _____
Family Physician: _____ Tel#: _____
Patients Employer: _____ Work Tel #: _____
Employer Address: _____ City: _____
State: _____ Zip: _____
Occupation: _____

INSURANCE INFORMATION

Subscriber Name: _____ Relationship to Patient: _____
Subscriber SS#: _____ Subscriber DOB: _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ALL CLAIMS

Patient's Signature: X _____ Date: _____

I AUTHORIZE THE RELEASE OF PAYMENT FOR MEDICAL BENEFITS TO MY PHYSICIAN, JOHN S. KUNG, MD. I, _____, UNDERSTAND THAT I AM 100% RESPONSIBLE FOR PAYMENT TO DR. KUNG IF THE INSURANCE COMPANY DOES NOT PAY.

Patient's Signature: X _____ Date: _____