PATIENT INFORMATION

Date: _____

Patients Name: _____ _____
(last name) (first name)

Birthdate: _____ **M or F** **Marital Status: M D S W**

Address: _____

_____

Phone number: _____ **Cell:** _____

E-Mail: _____

How / Whom referred you to our office?

_____

Name of Insurance: _____

Primary Holders Name: _____

Insurance ID# _____ **Group#** _____

SSN#: _____ **DOB:** _____
(primary holders)
Address: _____

_____

The fee for service is an obligation of the patient and is due at the time of service. If you have medical insurance, we will assist in obtaining full allowable benefits. But in the event the insurance company refuses previously confirmed coverage or reimburses a lesser amount than charged, the patient is fully responsible for the entire obligation. Any service not covered by your insurance company must be paid at the time of service.

I fully understand that I am directly and fully responsible to Total Family Eyecare for all medical bills submitted by TFC, or its agents, for services rendered to me.

Authorized Signature: _____

Print Name: _____