THURMOND EYE CENTER

Patient Information

First Name: _____ MI: _____ Last Name: _____

SS #: _____-_____-_____ Birthdate: _____/_____/_____

Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

E-mail: _____

Occupation: _____ Employer: _____

Primary Medical Dr.: _____ City: _____

Insurance Information

Policy Holder Name: _____ Relationship to Patient: _____

SS #: _____-_____-_____ Birthdate: _____/_____/_____

Person Responsible for Bill: _____

Address (if different): _____ *Apt/Unit #:* _____

City: _____ *State:* _____ *Zip:* _____

Home Phone: (_____) _____-_____ *Cell Phone: (_____)* _____-_____

How did you hear about our office?

□ Friend/Relative □ Internet □ Driving By □ Advertisement □ Other

Fee Schedule:

Examination charges are based on the professional time utilized for each particular procedure. Our physicians require ***retinal photography**** to be done on all patients annually.

****This will require an additional charge of $39.00 to your comprehensive examination.***

Payment Policy:

Physician Fee(s): All professional fees are due on the day services are rendered.

Contacts/Eyeglasses: Payment is required before ordering.

Assignment of Health/Vision Insurance Benefits:

I hereby assign all insurance benefits to Thurmond Eye Center for services rendered in their office. This assignment includes benefits payable to Medicare, Medicaid and all other health/vision insurance programs of which I am beneficiary. I authorize the release of all information from all sources necessary to secure payment for services rendered. The undersigned agrees to be responsible for any charges not covered by the above the provided sources.

Patient/Guardian Signature: _____ Date: _____/_____/_____