THE EYE CENTERS

Name_____ DOB_____ SSN _____

Age _____ ☐Male ☐Female

Address_____ City_____ State_____ Zip_____

Home Phone _____ Cell Phone _____

Work Phone _____ Email Address _____

Preferred Method of Contact ☐ Phone call ☐ Text

Marital status ☐Single ☐Married ☐Widowed

Emergency Contact: _____ Phone: _____

Relation to emergency contact: _____

Responsible Party other than self: _____

Address: _____ DOB _____ SSN _____

What is the name of your Primary Care Physician? _____

Military Status: ☐Active Duty ☐ Retired Branch of Service: _____

One Time Signature Authorization

Payment for all medical services is the responsibility of the patient and is expected at the time of service. There is a $15 service charge for all returned checks.

I request that payment of authorized Medicare and/or other insurance benefits be made either to me or on my behalf to Eye Centers of Tennessee as indicated on the claim form for any services furnished me by them. I authorize the release of any medical Information about me to the Health Care Financing Administration and/or insurance company(s) and their agents as necessary to process my claim.

I understand I am responsible for any deductibles, co-insurance or copays by my insurers, including the $40 refraction fee.

Signature of patient or responsible party _____

Received Privacy Policy _____