WOODSVILLE EYE CARE CENTER

Patient Information Form

First Name_____Middle Initial_____Last Name_____ Title: Mr. Mrs. Ms. Dr.

Name you wish to be called_____ Date of Birth_____ Age_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Email_____

Occupation_____ Social Security#_____

Employer_____ Work Phone_____

Spouse_____ If patient is a child, parent/guardian's name_____

Please present your insurance cards at the front desk at the time of your visit.

I acknowledge that I have been given the opportunity to read, and or obtain, a copy of Woodsville Eye Care's privacy notice.

I authorize the release of any medical or other information to process my insurance claims. I also authorize payment of medical benefits to my doctor. It is my understanding that I am responsible to obtain any and all referrals that my insurance company requires for services performed by my doctor. I also understand that I am responsible for any charges not covered by my insurance.

Our policy: Payment for professional services is expected when services are rendered. A deposit is required on all orders, and the balance is due to be paid upon delivery of any eyewear or contact lenses.

Signature	Date