DeWinter Eye Care Center Patient Information

Formal Name: _____**Date of Birth**:_____**Gender:**____

Street Address: _____

City:_____**State:**____**Zip**:_____ **Home Phone:**_____

Work Phone:_____**Cell Phone:**_____

Email Address:_____

May we contact you by email? ___Yes ___No Occupation: _____

Employer:_____**Social Security#**_____

Vision Insurance:_____**Identification#**_____

Medical Insurance: _____**Identification #**_____

Other:_____**Identification #**_____

Name of Insurance Card Holder:_____

Date of Birth of Card Holder:_____

Social Security # of Card Holder:_____

Employer:_____

PAYMENT TERMS: We are happy to assist you in the filing of your insurance claim. If your insurance company pays you directly we ask that you pay the balance. Our financial policy states that any out-of-pocket portions, co-pays, deductibles, for both services and products are paid for at the time of services. We accept cash, personal checks, Visa, Discover, and MasterCard.

I have read and agree to all the provisions of the financial policy.

Signed:_____ **Date:**_____

I authorize the release of information regarding my medical care and / or medical records to the following person(s) either, in writing, or by phone.

Name _____**Relationship**_____

Name _____**Relationship**_____