BILLINGSLEY EYE CARE

PATIENT INFORMATION
LEGAL NAME: ______________________________ , ________________________, _______
Last Name, First Name, Middle Initial

Street Address ____Apt. # __________

City _______________________________ State ________________________ Zip _________

Phone:___________________________ Alt. Phone:____________________________

SS#:_______________________ Date of Birth: ______________________ Sex: M or F

Marital Status ______________ E-MAIL ADDRESS:___________________________________

Responsible Party (If patient is a minor, parent or guardian should complete this section.)

Responsible Party: __________________________ , __________________________, _______
Last Name, First Name, Middle Initial

Relationship to patient:________________________ Home Phone Number: ________________

E-MAIL ADDRESS _______________________________SS#:__________________________

Date of Birth:_______________

Street Address ____ Apt.#______________

City___________________________State________________________Zip________________

Employer Name: _____________________________ Work Phone:______________ ext. _____

Employer Address: ____
Street Address City State Zip
METHOD OF PAYMENT ______Cash ______Check ______Credit Card ______ Ins.________

How did you hear about our practice? ____
Please indicate the person's name, internet site, advertisement, doctor's office, etc. that referred you to us.

Referring/Primary Care Physician:
Dr. ______________________ __________________________________ ______________
First Name Last Name, Phone Number

Name of Medical & Vision Insurance Companies
Primary Insurance Company Name: ____
Vision and/or Secondary Ins. Co. Name
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*Only need name of insurance, we will make a copy of your insurance card with the detail information

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AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS I hereby authorize the release of any information necessary to process my insurance claims. I authorize payment directly to the Physician for any professional services rendered to my dependent or me. I further understand that I am financially responsible for any charges not paid by my insurance company, unless my insurance plan is one that contracts directly with the Physician and they determine that I am not responsible. Regulations pertaining to medical assignment of benefits apply. In the event it becomes necessary to collect the amount due on my account by legal litigation, the handling fees, service charges or court costs will be paid by the guarantor. In order to prevent the application of the above, fees should be paid timely upon completion of rendered services.

Signature of Patient (or parent/guardian if a minor)

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Date _______________