PATIENT INFORMATION

Print Name: _____

Birthday: Month: _____ Day: _____ Year: _____ Age: _____ Sex: M F

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: (___) _____ Work #: (___) _____ Cell #: (___) _____

Spouse Name: _____ Work #: (___) _____ Cell #: (___) _____

Insurance Name: _____ Number: _____

Insured's Employer: _____

Insured's DOB: _____ Insured's SS#: _____

Medicare Number: _____ Medicaid: _____

Nearest Relative: _____ Phone#: (___) _____

Referring Physician: _____

PLEASE PRESENT INSURANCE CARD(S) TO THE RECEPTIONIST

I request that the payment of authorized medical benefits and any other insurance benefits be made either to me or on my behalf to Oklahoma Retina, PLLC for any services furnished to me. I authorize any holder of medical information about me to release to Medicare/Insurance carriers and its agents any information needed to determine these benefits payable for related services. Ultimately, I understand that I am responsible for payment for all services.

Signature: _____ Date: _____

Method of payment: ❑ Cash ❑ Check ❑ Credit Card (Visa, MC, Disc.)