SHELLY RICE OD PC INC

Rice Family Eye Care
512 E. Cherokee St. Wagoner, OK
918-485-4775 phone 918-485-7611 fax

Patient's Full Name _____ Date of Birth _____ Age ____ M or F
Parent or Legal Guardian's Name (If patient is under 18 years of age) _____
Relationship to the Patient _____
Patient's Home Address _____
City _____ State _____ Zip code _____
Home Phone # _____ Work Phone # _____ Cell # _____
Social Security # _____ Marital Status _____
Patient's Occupation _____ Employer's name _____
Employer's Address _____ City _____ State _____
Spouse's Name _____ Birthdate _____ Phone # _____
Spouse's Employer _____ Work Phone _____
Who may we thank for referring you to our office? _____

Insurance Information

Primary Carrier _____ Policy Holder _____
Insured's ID # _____ Group # _____
Social Security # _____ Date of Birth _____
Patient's relationship to Insured: □Self □Spouse □Child □Other _____

Secondary Carrier _____ Policy Holder _____
Insured's ID # _____ Group # _____
Social Security # _____ Date of Birth _____
Patient's relationship to Insured: □Self □Spouse □Child □Other _____

Emergency Contact: Name _____ Phone # _____ Relationship _____
Is there a power of attorney on this patient? □Yes □No
List all who are authorized to receive patient personal information from our office:

_____

I acknowledge that I have received a copy of the SHELLY RICE OD PC INC Notice of Privacy Practices.

Print Patient's Name	Patient Signature (Parent or Legal Guardian's Signature If patient is under 18 years of age)	Date
_____	_____	_____

I certify that the information given by me is true and correct. I request that payment of the authorized benefits be made directly to SHELLY RICE OD PC INC. for any services and or materials furnished and authorize the claim to be filed by SHELLY RICE OD PC INC. to the above insurer on my behalf. I understand that I am financially responsible for any charges not covered by this assignment unless otherwise arranged. I authorize the release of any information needed to provide medical treatment and services or to obtain authorizations or payments from the insurance company or other physicians associated with my care.

Patient Signature (Parent or Legal Guardian's Signature If patient is under 18 years of age)	Date
_____	_____

FEE FOR EXAMS IS DUE AT TIME OF SERVICE. 50% OF MATERIAL FEE IS DUE WHEN THE MATERIALS ARE ORDERED AND THE BALANCE IS DUE WHEN THEY ARE DISPENSED. THANK YOU!