RYAN EYE CARE
PATIENT INFORMATION

Mr./Mrs/Miss____
Last Name First Name Middle

____
Street Address APT # City State 9 Digit Zip

____
Date of Birth Age Sex Marital Status

____
E-Mail Address

____
Home Phone Cell Phone Social Security Number

____
Employed by Occupation Work Phone

____
Spouse's Name Occupation Work Phone

____
Nearest friend or Relative Relationship Phone Number

____
Family Physician Phone Number

Referred by:______ Friend / Relative ______ Newspaper ______ Physician
______ Yellow Pages ______Mail/Radio/TV Physician Name______________

PAYMENT INFORMATION

All payments are due at the time of service unless other arrangements have been made.
Please complete the section below, if someone other than the patient is responsible for the payment of services.

____
Name

____
Address City State Zip Phone Number

INSURANCE

I request that the payment of authorized benefits be made on my behalf to Ryan Eye Care. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare / Medigap or all other insurance's for payment. I authorized the release of any medical information necessary to process this claim and request payment of benefits to Ryan Eye Care. I understand that even though I have insurance coverage, I am responsible for payment of services.

Signature______________________________ Date______________________