Patient Information
(Please Print)

Today's Date:________________ Whom should we thank for referring you: ____________________________________

Name: ____ Phone (hm):_______________(wk):_____________

Address: _______________________________ City: _______________________ State: __________ Zip: __________

Birth Date: ______________________ Social Security #:__________________ Last Eye Exam: _______________

Occupation:_________________ Employer: ________________________ Phone: ________________________

Name of Medical Doctor:______________DR's Phone:_________________Last Medical Exam: ________________

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Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed

Spouse's Name: _________________________________ Phone: ____________________________________

Birth Date:_________________________ Social Security #: ______________________________________

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Person to contact if unable to reach you:

Name / Address: ____ Phone: ______________________________

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PAYMENT IS DUE WHEN SERVICES ARE RENDERED.

Please check the payment plan that you prefer and sign in the space indicated:

Cash or Personal Check ☐ MasterCard / Visa / Discover / American Express ☐

Medicare ☐ Medicaid ☐ GSU BCBS ☐ Lions Club ☐

Other: ____

Will you be filing with any insurance carrier for reimbursement of any exam fees incurred today? Yes No

Office Staff: _____________________________ Patient or Responsible party: _____________________________
Signature Signature

I authorize release to my insurance company, referring physicians or other groups, any information required for services provided and I authorize payment of medical benefits to Dr. Horace Deal, O.D.

I also understand that I remain responsible for any and all charges not met by the insurance company. Accounts more than 30 days past due may be subject to finance charges.
If my account should become in Default, then I agree to pay all costs of collection including but not limited to: court costs, attorney's fees, and collection agency fees.

Signature_______________________________ Date ______________________________