Garrett Eye Center
Patient Financial Information

NAME ____________________ ACCT# ____________
ADDRESS ____________________________________
____
PHONE ____________________ WORK PHONE ____________
BIRTHDATE ____________________ SOC SECURITY # ____________
MALE ______ FEMALE _______ MARRIED ______ SINGLE______
NAME OF SPOUSE ______________________________
NEAREST RELATIVE NOT LIVING WITH YOU ____________
RELATIVE'S PHONE NUMBER ______________________
FAMILY DOCTOR _______________________________
E-MAIL: _____________________________________
OCCUPATION/LINE OF WORK ______________________
EMPLOYER NAME & ADDRESS ______________________
____
____________________________ PHONE ____________
WORKER'S COMP ___YES ____NO DATE OF INJURY____________

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. I UNDERSTAND THAT A REFRACTION IS USUALLY REQUIRED FOR ANY EYE EXAM AND THAT REFRACTIONS ARE A NON COVERED SERVICE BY MEDICARE AND MOST COMMERICIAL INSURANCE COMPANIES. I WILL BE RESPONSIBLE FOR REFRACTION CHARGES. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR BOOKKEEPER. IF COLLECTION PROCEEDINGS ARE NECESSARY FOR PAYMENT OF SERVICES, THERE WILL BE A $25 FEE.
SIGNATURE OF PATIENT/RESPONSIBLE PARTY______________________DATE__________

IF PATIENT IS A MINOR, COMPLETE FOR RESPONSIBLE PARTY:

NAME____
ADDRESS_____________________________________
PHONE ____________________ BIRTHDATE____________
SOC SECURITY # ______________________________
DRIVER'S LIC #__________________________ STATE____________
EMPLOYER NAME & ADDRESS______________________
____
____________________________ PHONE____________