

PATIENT INFORMATION

Last Name	First Name	Middle Name	
Sex	SSN	Date of Birth	Marital Status
Street Address	City	State	Zip
Home Phone	Cell Phone	Work Phone	
Employer	Employer's Address		

SPOUSE INFORMATION

Name	Date of Birth	SSN	
Street Address	City	State	Zip
Spouse Employer	Employer's Address		

GUARANTOR

Person Responsible For Bill	Relationship to Patient		
Phone Number	Address	City	Zip

INSURANCE INFORMATION

Name of Company	Policy Holder	Relationship to Patient
Subscriber ID#	Group#	Plan#

EMERGENCY CONTACT

Name	Relationship to Patient
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Home Phone	Work Phone	Cell Phone
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Name	Relationship to Patient
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Home Phone	Work Phone	Cell Phone
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ASSIGNMENT/PATIENT SIGNATURE

I request that payment of benefits be made to Athens Eye Care Center, P.C. I authorize any holder of medical information about me to release the information needed to determine the benefits payable. I understand certain routine services may not be covered by my insurance. I will be expected to pay for those services in full. I understand and agree that all services and materials provided by Athens Eye Care Center, P.C. are non-refundable. I realize that all charges incurred by me and my dependants are my financial responsibility. Failure to make payment as stated above is basis for legal action and I agree to pay all court costs, reasonable attorney fees, or other fees necessary to collect any past due balances. I hereby waive all rights of exception under the laws of the state of Alabama. I have read the above policies and agree as indicated by my signature.

Signature	Date
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