EYE CONSULTANTS, INCORPORATED

C. NELSON RINGER, M.D. TODD J. LUMSDEN, D.O. JOHN R KINDER, M.D.
RICHARD L KIES, M.D.—T K KRUMMENACHER, M.D.—BYRON A SANTOS, M.D.

PATIENT INFORMATION

PLEASE PRINT CLEARLY

DATE ____________________ PATIENT'S FULL NAME ____

ADDRESS ____

CITY ____________________________ STATE__________________ ZIP CODE ________________________

HOME PHONE # ________________________ BIRTHDAY ______________________ AGE ______________

SEX: M______ F______ PATIENT'S SOCIAL SECURITY # ______________________________________

SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED ☐

PATIENT EMPLOYED: FULL TIME ☐ PART TIME ☐ RETIRED ☐ STUDENT ☐

Name of Patient's Employer ____

Business Address ____

Occupation ___________________________Business Phone # (___) ____________________________

SPOUSE'S (OR RESPONSIBLE PARTY) NAME ____

Name of Spouse (or Responsible Party's) Employer ____

Business Address ____

Occupation _______________________________Business Phone # (___) ________________________

Social Security # _______________________________ Date of Birth ___________________________

PRIMARY INSURANCE CARRIER ____

Policyholder's Name _____________________________ Policy or ID # ___________________________
Group _________________________

SECONDARY INSURANCE CARRIER ____

Policy or ID # ______________________________

IF WORKMEN'S COMPENSATION CLAIM:

Person Responsible for Payment: ____

Address ____ Phone # ______________________

Contact Person for verification ____

Workmen's Compensation Carrier: ____

Employer's Name and Address if Different From Above: _______________________________________

Phone #: ________________________________

PLEASE COMPLETE FRONT AND BACK SIDE

IF LEGAL CASE:

Name of Attorney: ___________________________________ Phone # ___________________________

Address ____

IF AUTO ACCIDENT:

Person or Agent Responsible for Payment ____

Address ____

Phone # _____________________________Date of Accident ____________________________________

Name of Insured ____________________________________ Claim # ___________________________

NEAREST RELATIVE NOT AT SAME ADDRESS ____

Relationship __________________________ Phone # (______) ________________________________

All professional services rendered are the ultimate responsibility of the patient. If your insurance company will be helping take care of all or a portion of your bill, your signature will be needed to expedite your claim.

It is necessary that we make a copy of your insurance card. Please be sure that you give us your current insurance card.