Patient Information

Patient Name: _____Date Of Birth: _____

Patient Address: _____City: _____State:_____ Zip: _____

Responsible Party (Minor Only): _____Social Security #: _____

Bill to Address: _____City: _____ State: _____Zip: _____

Home Phone: _____Work Phone: _____

Employer: _____

Spouse Name: _____Social Security #: _____

Spouse's Employer: _____Work Phones: _____

Emergency Phone Number: _____

Check One:

- ☐ I presently do not have vision insurance coverage.
- ☐ I have vision insurance but will submit the claim myself.
- ☐ I would like my insurance company billed for the coverage allowed.

Whom may we thank for referring you? __Insurance Co. __Friend or Family __Yellow pages __Other

I hereby authorize Apple Contact Lens Center to release information to and receive payment from my insurance company with my signature on file. (You are responsible for any non-payment billed services or materials not paid by your insurance.) I have read and understand the notice of Private Practice.

*I agree to pay all attorneys fees, court costs, filing fees and collection costs. Up to 50% of amt. owing may be assessed by any collection agency retained to pursue the matter. I agree to pay interest @ rate of 1.5% per mo.

Signed: _____ Date: _____