SHELLY RICE OD PC INC

Rice Family Eye Care
512 E. Cherokee St. Wagoner, OK
918-485-4775 phone 918-485-7611 fax

Patient's Full Name _____ Nickname _____
Patient's Home Address _____
City _____State _____Zip code _____
Home Phone # _____ Cell Phone # _____Work #_____
Date of Birth _____ Sex: M or F Social Security # _____
Email _____ Preferred Contact: Email Mail/Home#/Cell#/Text/Work#
Married: Y or N Hispanic or Latino?: Y or N, Race:_____ Smoking Status: Current/Former/Never
Patient's Occupation _____ Preferred Language _____
Parent/Guardian's Name_____ Relationship_____ Phone#_____
Emergency Contact_____ Relationship _____Phone #_____
Primary Physician_____ Phone#_____
Preferred Pharmacy _____ Location _____ Phone#_____
Employer_____ Phone#_____
Who is responsible for payment? _____

Insurance Information
Primary Carrier_____ Policy Holder_____
Insured's ID #_____ Group #_____
Social Security #_____ Date of Birth_____
Patient's relationship to Insured: □Self □Spouse □Child □Other_____
Secondary Carrier_____ Policy Holder_____
Insured's ID #_____ Group #_____
Social Security #_____ Date of Birth _____
Patient's relationship to Insured: □Self □Spouse □Child □Other_____

List all who are authorized to receive patient personal information from our office_____
_____

I acknowledge that I have received a copy of the SHELLY RICE OD PC INC Notice of Privacy Practices.

_____ _____ _____
Print Patient's Name Patient Signature Date
(Parent or Legal Guardian's Signature If patient is under 18 years of age)

I certify that the information given by me is true and correct. I request that payment of the authorized benefits be made directly to SHELLY RICE OD PC INC. for any services and or materials furnished and authorize the claim to be filed by SHELLY RICE OD PC INC. to the above insurer on my behalf. I understand that I am financially responsible for any charges not covered by this assignment unless otherwise arranged. I authorize the release of any information needed to provide medical treatment and services or to obtain authorizations or payments from the insurance company or other physicians associated with my care. I understand that prescription materials purchased from SHELLY RICE OD PC INC are non-refundable.

_____ _____
Patient Signature Date
(Parent or Legal Guardian's Signature If patient is under 18 years of age)

FEE FOR EXAMS AND MATERIALS IS DUE AT TIME OF SERVICE. THANK YOU!