

Name \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone (\_\_\_\_\_) \_\_\_\_\_ Work phone(\_\_\_\_\_) \_\_\_\_\_

 Date of birth \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

 Marital status  Single  Married  Widowed

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

If retired, former occupation \_\_\_\_\_

Friend or relative not living with you \_\_\_\_\_ Phone(\_\_\_\_\_) \_\_\_\_\_

Spouse's name \_\_\_\_\_ Spouse's SS# \_\_\_\_\_

Spouse's employer \_\_\_\_\_ Spouse's DOB \_\_\_\_\_

Responsible party if other than self \_\_\_\_\_ Phone(\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ SS# \_\_\_\_\_

**Insurance:**

- |  |                                      |                                       |
|--|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Medicare                  | <input type="checkbox"/> Aetna       | <input type="checkbox"/> VSP          |
| <input type="checkbox"/> United Health Care        | <input type="checkbox"/> Cigna       | <input type="checkbox"/> Eye Med      |
| <input type="checkbox"/> Blue Cross/Blue Shield    | <input type="checkbox"/> AmeriChoice | <input type="checkbox"/> Spectera     |
| <input type="checkbox"/> TennCare Select/Blue Care | <input type="checkbox"/> AmeriGroup  | <input type="checkbox"/> Block Vision |
| <input type="checkbox"/> Other insurance _____     |                                      |                                       |

**Referred by:**

- |   |
|---|
| <input type="checkbox"/> Physician (M.D.) _____   |
| <input type="checkbox"/> Optometrist (O.D.) _____ |

**Pharmacy:** \_\_\_\_\_

### One Time Signature Authorization

Payment for all medical services is the responsibility of the patient and is expected at the time of service. There is a \$15 service charge for all returned checks. We will bill your insurance in case of surgery.

I request that payment of authorized Medicare and/or other insurance benefits be made either to me or on my behalf to Eye Centers of Tennessee as indicated on the claim form for any services furnished me by them. I authorize the release of any medical information about me to the Health Care Financing Administration and/or insurance company(s) and their agents as necessary to process my claim. I also agree to be responsible for any deductions, co-insurance or disallowance of payments by my insurers.

 Signature of patient or responsible party \_\_\_\_\_  
 (DO NOT WRITE IN THIS SPACE ↓)