J.M. White, O.D. & Associates, P.A.

Welcome to J. M. White, O.D. & Associates, P.A. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name ____ MI ____ Last Name ____

Street Address Apt. # City State Zip

Social Security Number ____ Date of Birth ____ Home Phone (Include Area Code) ____ Work/Cell Phone ____

Email Address ____ Spouse or Parent(s) Name ____ Responsible Party for Account ____

What is the main reason for today's exam?________________________ When was last exam? ____________

General Practitioner? ______________________________ Phone Number _____________________________

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient (Please name)________

☐ Insurance Listing ☐ Drive by ☐Other _____________ ☐ Doctor (Please name)________

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company City State Zip

☐ M ☐ F ____ Insured's First Name ____ MI ____ Insured's Last Name

Insured's Identification Number ____ Group Number ____ Insured's Date of Birth ____

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other

☐ FT Student ☐ PT Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company City State Zip

☐ M ☐ F ____ Insured's First Name ____ MI ____ Insured's Last Name

Insured's Identification Number ____ Group Number ____ Insured's Date of Birth ____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Height: ____ft. _____inches

Weight: ______lbs. Preferred Language:__________________________

Please indicate your Race:

___ American Indian or Alaska Native
___ Asian
___ Black or African American
___ Native Hawaiian or Other Pacific Islander
___ White
___ Native American
___ Caucasian
___ Other Race
___ Refuse to Specify
___ Not Disclosed

PLEASE READ:

In order to control the cost of billing, we ask that the patient's portion be paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge.

Payment from my insurance(s) is to be paid directly to J. M. White, O.D. & Associates, P.A. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that the final determination can only be made when the claim is processed.

____ _______________________

Signature Date