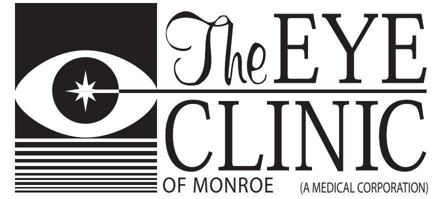
WELCOME TO



Joseph B. Barron, M.D. • Bryan J. Vekovius, M.D.

Patient Name ______________________ Date ____________

Address ______________________ City ____________ State _____ Zip ________

Birthday ____________ SS # ______________ Home Phone # ______________

Cell Phone # ______________ Work Phone # ______________ Ext. _______

Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ Sep Sex: M or F

HOW DID YOU HEAR ABOUT US? ______________________

PAYMENT TODAY WILL BE MADE BY: ☐ CASH ☐ CHECK ☐ CREDIT CARD

PATIENT INFORMATION:

Patient's Employer ______________________ Phone # ____________ Ext. _______

Employer's Address ______________________ City ____________ State _____ Zip ________

Spouse's Name ______________________ SS # ______________ DOB ________

Spouse's Employer ______________________

Spouse's Employer's Address ______________ City ____________ State _____ Zip ________

Spouse's Cell Phone # ______________ Spouse's Work Phone # ______________ Ext. _______

IF MINOR, PLEASE COMPLETE THE FOLLOWING:

Father's Name ______________________ SS # ______________ DOB ________

Father's Home Address ______________ City ____________ State _____ Zip ________

Father's Employer ______________________

Father's Employer's Address ______________ City ____________ State _____ Zip ________

Father's Cell Phone # ______________ Father's Work Phone # ______________ Ext. _______

Mother's Name ______________________ SS # ______________ DOB ________

Mother's Home Address ______________ City ____________ State _____ Zip ________

Mother's Employer ______________________

Mother's Employer's Address ______________ City ____________ State _____ Zip ________

Mother's Cell Phone # ______________ Mother's Work Phone # ______________ Ext. _______

- OVER -

EMERGENCY CONTACT – NOT IN THE SAME HOUSEHOLD:

Name ______________________________ Relationship ______________________

Address ______________________________ City ______________ State _____ Zip _________

Cell Phone # ______________________________ Home Phone # ______________________________

Employer ______________________________ Work Phone # __________________ Ext. ________

Employer's Address ___________________________ City ______________ State _____ Zip _________

NEAREST RELATIVE – NOT IN THE SAME HOUSEHOLD:

Name ______________________________ Relationship ______________________

Address ______________________________ City ______________ State _____ Zip _________

Cell Phone # ______________________________ Home Phone # ______________________________

Employer ______________________________ Work Phone # __________________ Ext. ________

Employer's Address ___________________________ City ______________ State _____ Zip _________

IMPORTANT! PLEASE READ

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. In order to control your cost of billing, we request that charges not covered by your insurance be paid at the conclusion of each visit.

If this amount is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable towhich I am entitled including Medicare, private insurance and other health plans to The Eye Clinic of Monroe.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance.

Thank you for your cooperation.

I agree to the assignments and financial responsibilities shown on this form.

Signature: ____ **Date** ______________

NOTE: This form must be signed in order for us to file your insurance.