

Dr. Carl Ryan and Associates Welcome To Our Office

Welcome to Dr. Carl Ryan and Associates. 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. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Mr. Miss Mrs. Ms. Male Female

First Name MI Last Name Preferred Name

Street Address City State Zip

Social Security Number Date of Birth Home Phone - Include Area Code Work Phone

Email Address Spouse or Parent(s) Name Person Responsible for Account (Must sign at bottom)

Mr. Ms.

School Name Teacher Name Grade

Whats the main reason for today's Exam? When was your last exam?

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 **Patient Status**
 Self Spouse Child Other Single Married Other
 Full Time Student Part Time Student Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company City State Zip

M F

Insured's First Name MI Insured's Last Name

Patient Relationship to Insured

Insured's Identification Number Group Number Insured's Date of Birth Self Spouse Child Other

Please Read:

In order to control the cost of billing, we ask that the patient's portion is 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 on all returned checks.

Payment from my insurance is to be paid directly to Dr Carl J Rayn and Associates. I understand that my primary insurance will be billed. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature

Date