Dr. Doron Feder, Optometrist

PATIENT INFORMATION

ACTUAL ADDRESS IF DIFFERENT THAN MAILING ADDRESS

_____

_____

_____

LAST NAME: _____ FIRST NAME: _____ MIDDLE INIT: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME TEL #: _____ WORK TEL: ___ _____ EXT: _____

EMPLOYER: _____

SEX: MALE _____ FEMALE _____ SOCIAL SECURITY #: _____

_

BIRTHDATE: _____ / _____ / _____ AGE: _____ HEAD OF HOUSEHOLD: YES _____ NO_____

TITLE: MISS _____ MS.. _____ MRS. _____ MASTER _____ MR. _____ OTHER _____

MARITAL STATUS: SINGLE _____ MARRIED _____ OTHER _____

EMPLOYMENT STATUS: EMPLOYED _____ FT STUDENT _____ PT STUDENT _____

TODAY'S DATE": _____ / _____ / _____ ARE YOU A FORMER PATIENT _____ NEW PATIENT _____

INSURANCE INFORMATION:

PRIMARY CARRIER: _____

NAME OF INSURED: LAST NAME: _____ FIRST _____

INSURED'S ID#: _____ RELATIONSHIP: SELF _____ SPOUSE _____ CHILD _____

INSURED'S SOCIAL SECURITY NUMBER: _____

INSURED'S DATE OF BIRTH: _____ / _____ / _____

THE FOLLOWING STATEMENT MUST BE SIGNED IN ACKNOWLEDGMENT OF OFFICE POLICIES:

1. FULL PAYMENT IS EXPECTED AT TIME OF SERVICES UNLESS OTHER WRITTEN ARRANGEMENTS WITH THE DOCTOR HAVE BEEN MADE. IF YOUR INSURANCE COMPANY DOES NOT COVER THIS OFFICE VISIT, THEN PAYMENT FOR THIS VISIT IS YOUR RESPONSIBILITY.

_____ (SIGNATURE)

2. ANY RETURNED CHECKS RE SUBJECT TO A SERVICE CHARGE OF $55.00 AND ANY OTHER ADDITIONAL PROCESSING FEES.

_____ (SIGNATURE)

3. THERE IS A $5.00 PER MONTH BILLING CHARGE AND A 2% ACCRUED FINANCE CHARGE FOR ANY UNPAID BALANCES EACH MONTH. IF PAYMENT IS NOT RECEIVED WITHIN A REASONABLE AMOUNT OF TIME THEN ADDITIONAL COLLECTION CHARGES INCLUDING ATTORNEY FEES WILL BE ADDED TO THE CHARGES OF THE PREVIOUS BALANCE.

_____ (SIGNATURE)