

Welcome To Our Office!!

Michael F. Ringel, O.D.

Patient's Legal Name (Please Print):

Mr. _____ Mrs. _____ Miss _____ Ms. _____ Dr. _____

First _____ M.I. _____ Last _____

Parent/Guardian Name (if minor) _____

Mailing Address _____

E-mail Address _____

Occupation _____ Home Phone # _____

Date of Birth _____ Work Phone # _____

Social Security # _____ Cell Phone # _____

Insurance Information:

Insurance Comp. _____ Subscriber's Name _____

Subscriber's D.O.B. _____ Subscriber's Place of Employment _____

Financially Responsible Party _____

How did you select our office?

_____ Yellow Pages _____ Family Has Been In _____

_____ Insurance Booklet _____ Referred by _____

_____ Location _____ Other _____

Most insurance policies only pay a portion of your total charges. If you have questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not your insurance companys'.

SIGNED: _____

I authorize payment of medical benefits to Michael F. Ringel, O.D. for services and supplies rendered at the office.

SIGNED: _____

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED, INCLUDING NON-COVERED PORTIONS OF INSURANCE.