# 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.**