Eye Associates, PLLC
Devin A. King, M.D.

Patient Name._____ Today's Date_____

MailingAddress_____

City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____

E-mail address_____ Marital Status: Single Married Divorced Widowed

Social Security Number_____ Date of Birth_____ Age _____ Gender: M F

Employer/Parent's
Employer_____Occupation_____

Spouse name (Parent name if minor)_____DOB:_____Spouse/Parent Phone_____

Spouse or Parent's Social Security Number (if primary cardholder of insurance)_____

Person to notify in case of emergency (other than spouse)_____

Phone number
(s)_____Relationship_____

Referring physician**:**_____

Family doctor**:**_____

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Eye Associates, PLLC and/or Devin A. King, M.D. to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

_____ _____

Patient's signature **Today's date**