Douglas F. Ritchie, OD, MD
Jill K. Showalter, OD

Patient Information

Last Name ______________________ Suffix_______ First Name_____________________MI___

Gender: F /M Date of Birth: ________________ Email __________________________________

Mailing Address____

City____State__________________Zip_________

Home Phone(____)-_____-______Cell Phone (____)-____-_______Day Phone(____)-____-_______

Employer________________________________Occupation________________________________

Whom may we thank for referring you to us? ____

Responsible Party (*If different from the patient, please complete the following.)*

Last Name _______________________ Suffix_______ First Name___________________MI___

Mailing Address____

City_______________________________State_______________Zip_______

Cell Phone (___)-___-______ Texting Yes/No Email __________________________________

Home Phone(_____)-______-_______ Day Phone(____)-____-_______

Primary Insurance Information (Subscriber information)

Insurance Company_____________________________ Cardholder SSN______________________

Date of Birth_________ Insurance ID________________ Relationship to Cardholder____________

Secondary Insurance Information (Subscriber information if applicable)

Insurance Company_____________________________ Cardholder SSN______________________

Date of Birth_________ Insurance ID________________ Relationship to Cardholder____________

I authorize any holder of medical or other information about me to release to the S/S administration or any other carriers any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payment of insurance benefits either to myself or to the party who accepts assignment below. I understand that I am responsible for any costs in excess of the benefits payable by my insurance plan.

X Patient Signature____Date___________

Notice of Privacy Practices:
I acknowledge, by my signature below that I have been given the opportunity to review the Notice of Privacy Practices for Eyedoctors and I understand that I may request a copy of this notice should I choose. I agree to electronic communication of appointment reminders as indicated above and outlined in the Notice of Privacy Practices.

X Patient Signature____Date___________