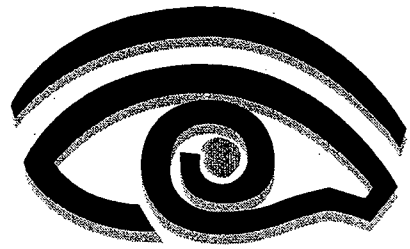
Brennan Eye Care

Dr. J. Patrick Brennan, Dr. Christine V. Brennan 710 S. Parrott Avenue, Okeechobee, Fl. 34974 Ph (863) 467-0595



WELCOME TO OUR OFFICE

(PLEASE PRINT)

LEGAL NAME_____ _____ _____
FIRST MI LAST

MAILING ADDRESS_____

CITY_____ST_____ZIP_____

HOME PHONE (____)_____ DAYTIME PHONE (____)_____

CELL PHONE (____)_____ PAGER NUMBER (____)_____

E-MAIL ADDRESS_____

SEX M/F DATE OF BIRTH_____ SS#_____

ARE YOU MARRIED, SINGLE, DIVORCED, OR WIDOWED?_____

EMPLOYMENT STATUS: FULL TIME, PART TIME, RETIRED OR UNEMPLOYED

EMPLOYER_____OCCUPATION_____

DO YOU WEAR CONTACT LENSES NOW?_____

ARE YOU INTERESTED IN CONTACT LENSES?_____

THE PERSON RESPONSIBLE FOR THE BILL, IF DIFFERENT FROM ABOVE?

LEGAL NAME_____RELATIONSHIP_____

PHONE NUMBER (____)_____SS#_____DOB_____

HOW DID YOU HEAR ABOUT OUR OFFICE?_____

IF A PERSON OR DOCTOR, PLEASE NAME_____

NOTE:*DUE TO NEW INSURANCE RULES AND REGULATIONS, WE NEED COPIES OF* ***ALL*** *OF YOUR INSURANCE CARDS AND DRIVERS LICENSE AT THE TIME OF THIS VISIT.*

FINANCIAL AGREEMENT:

I agree that in return for services provided to me by **Dr. J. Patrick Brennan** and/or **Dr. Laurie McConnell**, I will pay my account at the time services are rendered. I agree to pay any copays or deductibles that are assigned from my insurance company. If **Dr. J. Patrick Brennan** and/or **Dr. Laurie McConnell** are not providers for my insurance, I understand that I am responsible for payment in full.

X_____ X_____
LIFETIME SIGNATURE DATE

INSURANCE SIGNATURE ON FILE:

I certify that the information given by me is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and authorize payment of these benefits directly to J. Patrick Brennan, O.D. on my behalf for any services and materials furnished.

X_____ X_____
LIFETIME SIGNATURE DATE