Page 2 patient information

INSURANCE INFORMATION

Name of Insured _____Relationship to Patient_____

Insured's Date of Birth_____ Social Security Number_____

I agree to the examination, diagnostic studies and treatment as deemed appropriate by Dr. R Lane Nutt, Optometrist and also to the release of information concerning that care for insurance purposes or for further medical care when necessary. I authorize my insurance benefits to be paid directly to the doctor. I hereby agree to pay all fees and finance charges that are not paid by my insurance company.

Signature of Guarantor_____ Date_____

Consent for treatment of Minors

Name of Minor_____

Parent/Guardian Name_____

Address_____
Street/ P O Box City State Zip

Parent/Guardian Signature_____ Date_____

PLEASE NOTE IT IS IMPORTANT TO BRING ALL INSURANCE CARDS WITH YOU TO YOUR VISIT IN OUR OFFICE.