Lincoln County Vision Center Bill Womble, O.D.

1822 Huntsville Hwy Suite D Fayetteville, TN 37334 (931) 433 - 1370

- NID OT	1400		X 100	
Name of person being seen today: FIRST	MID	DLE	LAST	
Address: No. & STREET	CITY	STATE	ZIP CODE	
Home phone: Wo	rk phone:	Cell phone:		
() Male () Female Birthdate:	e: Email address:			
() Married () Single () Divorced () Widowed Soci	al Security #		
Employer:	Occupation:_			
Spouse's name:	Employer:			
Insurance Company Name & Address:				
Insurance ID # Group #				
Is this insurance thorough your employer?	() yes () no If so	o, please fill in the follow	ving information	
mployer name: Phone #				
Who works there ?	Birthdate:			
Relationship to Patient: () Father ()	Mother () Legal Guard	dian () Other ()	I do not have insurance	
If the patient being seen today is UNDER th				
Parents are:		MOTHER		
Parents phone:FATHER				
Father's Birthdate		SS #		
Mother's Birthdate		SS #		
Refraction (measurement of glasses prescr which will be collected with copayment.	ription / and or contacts)	is not covered by medic	cal insurance. There is a \$30 charg	
I DO consent to refraction	I DO NOT	consent to refraction_		
I request that payment of authorized Medicare ber William C. Womble, O.D. for any services furnish the Health Care Financing Administration and its benefits or the benefits payable for related service effect until revoked by me in writing. A photocop acknowledge that I have received a copy of Dr. B	hed me by that provider. I aut agents, or any third party payo s. This release applies to all s py of this assignment is to be of	horize any holder of medic or (to include Medigap), an ervices now and in the futu considered as valid as the o	al information concerning me to release to by information needed to determine these are. These assignments will remain in	

Patient or Parent / Guardian Signature: ______ Date: ____