Dr. Heather Sohrabi
921 N. Washington St.
Tullahoma, TN 37388
931-455-5554

Pharmacy Used ______________________ City ____________

Patient Registration

Mr. ____ Mrs. ____ Ms. ____ Dr. ____ Other ____ Date: ________________
Patient Full Legal Name: ____ Nickname: ______________
Is the patient a minor? ____ Yes ____ No, if yes, please list the name of their school: ____________________
Address: ____ Email: __________________________
City: ___________________________ State: ____________ Zip: ______________________________
Home phone #:_____________________ Work phone # ______________________ Cell # ______________
Date of Birth: ______________________ Social Security # _______________________
Ethnicity: Caucasian _____ Hispanic _____ African American _____ Asian _____ American Indian _____ Other _____
Employer: _________________________________
Employement Status: Full time ____ Part time ____ Retired ____ Not Employed _____ Active Duty Military ____
Sex: M ____ F ____ Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Separated ___
Spouse's Name:________________________
Nearest Relative or Friend NOT living with you: ____
Relationship: ____________________________ Phone # ______________________________
How did you hear about us? ____
Who else in your family have we seen before? ____

Name of person responsible for this account ____
Address: ____________________________________City: ________________ State: ______ Zip: ______
Home phone #:_____________________ Work phone # ______________________ Cell # ______________
Relationship to patient: Self _____ Spouse _____ Parent _____ Guardian _____
If Guardian please list relationship to patient: ____

Insurance Subscriber's Information

Medical Insurance

Name of Insurance ________________________
Name of subscriber _________________________
Subscriber's SS# __________________________
Date of Birth: ____________________________
Employer: _______________________
Employer's Address: ____
City: __________________________________ State: _______________________ Zip: _______________

Vision Insurance

Name of Insurance__________________________
Name of Subcriber__________________________
Subscriber's SS#___________________________
Date of Birth _______________________________
Occupation: _______________________________

Payments and co-pays are due when services are rendered. Contact lenses and/or materials must be paid for in full before they are released.

Excel Eycere, P.C. at its discretion, may place an unpaid account with an attorney or collection agency collection. In the event your account is referred to an attorney or collection agency for collection of unpaid charges, the patient (or person responsible for the account) agrees to pay an attorney or collection agency's fee, court cost, and any other reasonable cost of collection. Jurisdiction for any dispute is agreed to be exclusively in the courts of Coffee County, Tennessee.

Signature: ____ Date: ___________________________

MEDICARE PATIENTS ONLY

I request the payment of authorized Medicare benefits be made to Excel Eyecare, P.C. on my behalf. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature: ____ Date: ___________________________