Excel eyecare
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: _____

Vision Insurance

Name of Insurance_____
Name of Subcriber_____
Subscriber's SS#_____
Date of Birth _____
Occupation: _____

Employer's Address: _____
City: _____ State: _____ Zip: _____

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: _____