

TREVOR S. WHITE, O.D.  
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(405)262-6611

PATIENT INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Telephone #: \_\_\_\_\_ Work Telephone #: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medicare/Medicaid #: \_\_\_\_\_

Eye Care Insurance #: \_\_\_\_\_

Other: \_\_\_\_\_

Person Responsible for Payment: \_\_\_\_\_

Address: \_\_\_\_\_

Home Telephone #: \_\_\_\_\_ Work Telephone #: \_\_\_\_\_

Employer: \_\_\_\_\_

SIGNATURE ON FILE

I authorize use of this form on **all** my insurance submissions.

I authorize release of information to all my **Insurance Companies**.

I understand that **I am responsible** for my bill.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance company.

I authorize payment direct to my doctor.

I permit a copy of this authorization to be used in a place of the original.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_