TREVOR S. WHITE, O.D.
100 N. CHOCTAW
EL RENO, OK 73036
(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:_____