

**STIRLING EYECARE
PATIENT INFORMATION SHEET**

PATIENT NAME _____

Sex (circle one) M F

Marital Status (Circle one) M S D W

Patient Cell Phone # _____

PA Driver's License # _____

Who referred you to our office? _____

Vision insurance _____

Medical Insurance _____

Responsible party for this account? _____

Responsible party's address/phone if different from Patient

Address _____

Phone _____

***I authorize payment of medical or vision benefits either to myself or to Stirling Eyecare Center, for professional services rendered.

***I understand that all charges are due at the time of service and that:

I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefit. This may include, but is not limited to deductible, co- insurance, and/or co- pays.

Signature of Patient, or if under 18,
Parent or Guardian Signature

Date