Welcome To the office of

Dr. George Roebuck and Dr. Jennifer Jacobs

Name _____ Today's date _____

Address _____
Street city state zip

Birthday ___/___/_____ Social Security #_____

Phone #_____ Cell #_____

E-Mail _____ Do you accept text? _____

(circle one)

Race: American Indian Asian African American Hispanic White

Place of employment_____

Work Address _____ Work Phone _____

(If Child) Parent's names _____

_____

Who is responsible for bill? _____

Responsible party address _____

Responsible party phone # _____

Insurance company for Vision _____

Insurance company for Medical _____

Insured's name (*if different*) _____ Social Security # _____

Insured's Birthday___/___/_____

Insured's place of employment_____

Insured's address (if different than patient) _____

I understand that although I may have insurance, I am ultimately responsible for the bill.

I authorize you or any agent of your office to contact me on my cell phone.

"The undersigned also agree(s) to pay all collection costs incurred, in an amount not to exceed fifty percent (50%) of the unpaid balance, should any unpaid balance be referred to a collection agency, in addition, should any unpaid balance due be referred to an attorney for litigation, all reasonable attorney fees and court costs shall be paid for by the undersigned as allowed by the Court."

Signature _____ Date _____