William C. McMillin, OD

William P. McMillin, OD

McMillin eyecare
Focused Excellence

Phone 423-239-5491 • Fax 423-239-4860
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PATIENT INFORMATION

Patient Name _____
First Middle Last

Physical Address _____
Street City State Zip

Billing Address _____
Street City State Zip

Date of Birth _____ Patient Social Security # _____

Gender _____ Preferred Method of Contact _____

Phone #'s Home _____ Work _____

Cell _____ E-Mail Address _____

Married / Single (Circle one) Employer _____

How did you hear about us? _____ Referred by _____

Parent / Spouse (Circle one) Name _____ Date of Birth _____
*If a dependent, name of responsible party

Parent / Spouse (Circle one) Social Security # _____ Employer _____

Vision Insurance _____

Subscribers Name _____

Subscribers SS# _____ Subscribers Date of Birth _____

Primary Medical Insurance _____ **Secondary** _____

Subscribers Name _____

Subscribers ID# _____ Subscribers Date of Birth _____

Preferred Pharmacy _____ Pharmacy Phone # _____

Patient Medical Doctor _____ City _____

***We are a participating member of Medicare and we accept most vision and medical insurance plans. If we are not on your insurance plan, please let us know and we will do our best to offer you the same benefits.**
I authorize this office to release any information needed to process any insurance claim. I understand that I am responsible for any charges regardless of insurance coverage.

Signature of responsible party _____ Date _____

Our Mission is to treat each patient as an individual and to provide the highest quality vision care possible. We offer you and your family a lifetime commitment to the vision and health of your eyes.