WALKERSVILLE EYECARE

General & Insurance Information Form

8415 A-C Woodsboro Pike, Walkersville, MD 21793 | 301-898-3000 (office) | 301-845-4324 (fax)

Dr. Steven R. Allgaier | Dr. Rebecca J. Hub | Dr. Lisa G. Smith **WalkersvilleEyecare.com**

PERSONAL INFO 1

Today's Date _____

◯ Mr. ◯ Mrs. ◯ Miss ◯ Dr. ◯ Other _____

First Name _____

Last Name _____

Street Address _____

Street Address 2 (Apt #, etc.) _____

City _____ **State** _____ **Zip** _____

Email _____

Mobile Phone _____

Home Phone _____

Work Phone _____

Primary Care Physician _____

Doctor's Phone _____

Employer _____

Occupation _____ **Full Time?** ◯ Yes ◯ No

Date of Birth _____ **Age** _____ **SSN** _____

Gender
- ◯ Female
- ◯ Male

Preferred Communication
- ◯ Email
- ◯ Postal
- ◯ Phone

Preferred Language
- ◯ English
- ◯ Spanish

Marital Status
- ◯ Married
- ◯ Single
- ◯ Divorced
- ◯ Other _____

Race
- ◯ African American / Black
- ◯ American Indian / Alaska Native
- ◯ Hispanic
- ◯ Caucasian / White
- ◯ Other _____

If patient is a minor who is financially responsible?

Name _____ **Phone** _____ **Relationship to Patient** _____

INSURANCE 2

If no insurance, skip & go to Section 3

Name of Vision Care Insurance Company _____

Name of Primary Card Holder (the insured) _____ **Date of Birth** _____

Insurance ID or Membership # _____ **Group #** _____

Secondary Insurance Company & Member ID (if there is a secondary insurance carrier) _____

SIGN & DATE 3

Initial each box below and please sign

☐ I understand, confirmed by my signature below, that all discounts, discount plans, or insurance information must be submitted at time of services rendered and/or product(s) ordered, in order to utilize the benefit(s). Walkersville Eyecare will not honor benefits or discounts on prior services renedered &/or product(s) ordered. I have provided complete & accurate insurance information, in good faith. I understand that if my insurance company fails to pay for a properly submitted claim for services rendered on my behalf, &/or for my family member(s), then I am responsible for the payment, and will render it promptly. I authorize Walkersville Eyecare to release any medical or other information about me to my insurance company in order to process claims on my behalf.

☐ **My signature on this form will stand as my Signature on File.**

☐ **My signature below verifies that I received (was offered) a copy of the Notice of Privacy Practices for Walkersville Eyecare**

Patient or Guardian/Representative's Signature _____ **Date** _____

Relationship of Patient Representative to Patient _____