

**Walkersville Eyecare**  
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**8415 A-C Woodsboro Pike**  
**Walkersville, MD 21793**  
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### **Insurance / General Information Form**

\*\*\*Please fill this form out completely. If there is no insurance, then skip Section 2 and go to Section 3.

#### **SECTION 1:**

Date: \_\_\_\_\_ Gender:  Female  Male Race: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Title (check one):  Mr.  Mrs.  Ms.  Miss  Dr.  Other \_\_\_\_\_

Marital Status (check one):  Married  Single  Divorced  Other \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone #: (\_\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_\_) \_\_\_\_\_

Cell Phone #: (\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

#### **SECTION 2:**

Name of vision care insurance company: \_\_\_\_\_

Who is the primary card holder (insured)? \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

Insurance ID # or Membership #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of primary care physician: \_\_\_\_\_ Doctor's Phone #: (\_\_\_\_\_) \_\_\_\_\_

Is there a secondary insurance carrier? (Name & Member #)

\_\_\_\_\_

#### **SECTION 3:**

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 benefits(s).

Walkersville Eyecare will not honor benefits or discounts on prior services rendered and/or product(s) ordered.

Patient or Guardian's Signature \_\_\_\_\_ Date: \_\_\_\_\_

I have provided complete and 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, and/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.

Patient or Guardian's Signature \_\_\_\_\_ Date: \_\_\_\_\_