

**Walkersville Eyecare**  
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### **Insurance / General Information Form for a Minor Child**

Please fill out this form if the patient is a minor (under the age of 18) or if the patient is not personally responsible for their own medical expenses.

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

Patient's Address: \_\_\_\_\_

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

Home Phone #: (\_\_\_\_\_) \_\_\_\_\_ Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_  Male  Female

Email: \_\_\_\_\_

#### **Name of Parent(s) or Guardian:**

<b>Name</b>	<b>Work Phone:</b>	<b>Cell Phone:</b>
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Mother: _____	(_____) _____	(_____) _____
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Father: _____	(_____) _____	(_____) _____
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Guardian: _____	(_____) _____	(_____) _____
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Who is responsible for medical decisions regarding this patient? \_\_\_\_\_

Who is responsible for financial matters in regards to this visit? \_\_\_\_\_

Who referred this patient to our office? \_\_\_\_\_

#### **Billing information of responsible person (if different from address above):**

Name \_\_\_\_\_

Address \_\_\_\_\_

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

Email: \_\_\_\_\_

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 #) \_\_\_\_\_

Please list other family members who are patients of Walkersville Eyecare:

\_\_\_\_\_

Please be aware that polycarbonate is a lens material that provides extra safety in eyewear. Walkersville Eyecare strongly recommends you choose this material if your child needs eyeglasses.

Signature: \_\_\_\_\_