



General & Insurance Information Form

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

Dr. Steven R. Allgaier, O.D. - Dr. Rebecca J. Hub, O.D. - Dr. Jeffrey L. Reynolds, O.D. 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 _____

If patient is a minor who is financially responsible?

Name _____ Phone _____ Relationship to Patient _____

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 _____

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 rendered &/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 _____