USE BLACK INK

BALTIMORE WASHINGTON EYE CENTER

NAME:_____ AGE: _____ APPT. DATE: _____ DOCTOR: _____

STREET ADDRESS: _____ DOB: _____

CITY: _____ STATE: _____ ZIP: _____ SS#: _____

EMAIL ADDRESS: _____

HOME PHONE: (_____)_____BUSINESS PHONE: (_____)_____

Please Circle: Male Female Marital Status: S M W D SEP

Race: African American American Indian Asian Caucasian Hispanic Other: _____

Responsible Party, If child: _____
Address, If different: _____
Spouse's Name, If married: _____
Name, Address & Phone of nearest relative not living with you: _____

Responsible Party/Employer: _____
Employer Address: _____
Whom may we thank for referring you to our practice? _____
Who is your regular MEDICAL doctor? _____

INSURANCE INFORMATION

We expect payment at the time of service unless you are in a Plan in which we receive reimbursement. We will provide you with a coded insurance receipt.

PLEASE PRESENT ALL INSURANCE CARDS FOR COPYING

PRIMARY INSURER: Name and Address of Plan: _____

Subscriber's Name: _____ DOB: _____
ID Number: _____ Group Number: _____

SECONDARY INSURER: Name and Address of Plan: _____

Subscriber's Name: _____ DOB: _____
ID Number: _____ Group Number: _____

IF ACCIDENT: Workman's Comp: _____ Motor Vehicle/PIP: _____ PIP Deduct $: _____

MEDICAL LIFETIME SIGNATURE ON FILE: I authorize payment of Medicare benefits to the B.W. Eye Center for services rendered to me. I authorize release of medical information about me to the Health Care Financing Administration to determine benefits.

DATE: _____ **SIGNATURE:** _____

FINANCIAL AGREEMENT: I authorize payment of any insurance benefits for unpaid services to the BW Eye Center and I am responsible for any balances after insurance claims have been paid. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to BW Eye. In the absence of insurance, I agree that in return for the services provided by THE BALTIMORE WASHINGTON EYE CENTER, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to BW Eye for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate.

DATE: _____ SIGNATURE: _____

OVER→