Washington Eye Institute

5711 Sarvis Ave #402, Riverdale, MD 20737-1365
(301) 277-4844 FAX: (301) 927-3221

Welcome to Our Office

Thank you for choosing our office. In order to serve you properly, PLEASE PRINT the following information.			
Name:			Chart
Address:		City/State/Zip:	
SSN:	Birthdate:	Marital Status:	Gender:
Home Ph:	Work Ph:	Cell Ph:	
Email:		Other Contacts:	
Employer:	Address:		
Occupation:		Full/Part/Student/Retired/Other:	
Emergency Contact Name:			Relationship:
ER Contact Home Ph:		ER Contact Work Ph:	
How did you hear about us:			
If patient is a child, who may authorize treatment:			Relationship:
Person financially responsible for treatment if not Self:			
Address of person financially responsible:			Phone:

Race (circle one): African-American – Asian – Caucasian – Hispanic – Other – Decline to Provide

Ethnicity (circle one): Hispanic/Latino – Non-Hispanic/Latino – Decline to Provide

Language (circle one): English – Spanish – Other:_____ – Decline to Provide

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ _____

Insured: Name _____ DOB _____ Employer _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. and myself.

Signature _____ **Date** _____