Timothy P. Walker, O.D.

PATIENT INFORMATION

NAME_____ DATE____/____/____

First Name MI Last Name

ADDRESS_____ SSN_____

CITY_____ STATE_____ ZIP_____

DATE OF BIRTH____/____/____ AGE_____ SEX: M F

HOME PHONE_____ CELL_____ WORK_____

EMAIL ADDRESS_____ MARITAL STATUS: M S D W

EMPLOYER_____ OCCUPATION_____

PERSON RESPOSIBLE FOR BILL

IF DIFFERENT FROM ABOVE

PERSON RESPONSIBLE FOR ACCOUNT_____

First Name MI Last Name

RELATION TO PATIENT_____ DOB____/____/____ SSN_____

ADDRESS (IF DIFFERENT FROM PATIENT)_____

CITY_____ STATE_____ ZIP_____ PHONE_____

HEALTH INSURANCE INFORMATION

MEDICARE NO._____ SUPPLEMENTAL INS._____

COMPANY_____ POLICY NO._____ GROUP NO._____

VSP MEMBER NAME_____ SS#_____ DOB_____

AUTHORIZATIONS

BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the medical benefits. I understand I am responsible for any portion of my bill not covered by my insurance company. I also authorize release of information for insurance claim purposes. Photostat of the above is as valid as the original.

DATE_____ SIGNED_____