Dr. Daniel Wendorff & Associates, P.C.

Doctors of Optometry Next to Lenscrafters

Date:___________ Please write clearly

Mr. Mrs. Miss Ms. Dr. Rev.

Last Name:_______________________________ First_______________ MI________

Address:_______________________________ City_______________ ST______

Zip Code:__________ Home Phone:______________ Work Phone:______________ Cell:__________

Birthdate:_____/_____/______ E-mail address_____________________@_________________

SS#_____/_____/______ Name of Medical Doctor:_______________ Dr's Phone:_______________

Last Eye Exam _______________ From Dr._______________

Occupation:_______________ Employer:_______________

Responsible Party Name: _______________________________

Responsible Party Address:_______________________________

(If same as above write same)

Please list all Medications you are currently Taking:_______________________________

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If you have *Vision Insurance* please let front office staff know this Before your eye examination so we can obtain eligibility.

We are providers of many Medical Insurers. Some Exams/Office visits are covered under your medical plan. We need this information.

Please answer all questions if applicable. If we are to receive payment from your Insurer on your behalf, all information is mandatory.

Vision Insurance:_______________ ID #_______________ Group #__________

Name of Insurance Holder_______________ Date of Birth:_______________

Primary Medical Insurance:_______________ ID#_______________ Group #__________

Name of Insurance Holder:_______________ Date of Birth:_______________

Are you a dependent on another Medical plan? (Yes or No) If Yes, make sure you list the correct primary Medical insurance

Secondary Medical Insurance:_______________ ID#_______________ Group#__________

Name of Insurance Holder:_______________ Date of Birth:_______________

Medicare Supplement:_______________ ID#_______________ Group#__________

Name of Insurance Holder:_______________ Date of Birth:_______________

I authorize payment of benefits to Dr. Daniel Wendorff & Associates. I agree to be financially responsible for any balance not paid by my insurance plan.

Patient or Responsible Party _______________________________ Date_______________

Most Insurance Companies require us to file electronically. Since you cannot sign the electronic Ins. form we need your signature here.

Insurance Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment of these benefits be made to me or on behalf to Dr. Daniel Wendorff & Associates for any services and materials furnished. I authorize the holder of medical information about me to release to the Centers of Medicare & Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electronically submitted claim) my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

____ Date_______________

Patient Signature