

Dr. Daniel Wendorff & Associates, P.C.
Doctors of Optometry Next to Lenscrafters

Tech _____

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: _____

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