Welcome to Viewmont Eye Associates

Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

□ Mr. □ Miss □ Mrs. □Ms. □ Male □ Female Chart #_____

First Name | MI | Last Name | Preferred Name

Mailing Address | City | State | Zip Code

Social Security Number | Date of Birth | Primary Phone Number | Alternate Phone Number

E Mail Address | Parent's Name if Minor | Person Responsible for Account

Permission to send E Mail?
□ YES □ NO

Spouse's Name | Emergency Contact Name | Emergency Contact Phone Number

Patient's Employer | Work Phone Number

Patient's Primary Care Physician's Information:

PCP Name

Name of Practice

Preferred Pharmacy:

Name of Pharmacy

Pharmacy Location

Patient Status: □ Single □ Married □ Other □ Full-Time Student □ Part-Time Student □ Employed

Primary Insurance Information

Name of Insurance

Subscriber's Identification Number | Group Number

_____/_____/_____
Subscriber's Date of Birth

Patient's Relationship to Insured
□ Self □ Spouse □ Child □ Other

Secondary Insurance Information

Name of Insurance

Subscriber's Identification Number | Group Number

_____/_____/_____
Subscriber's Date of Birth

Patient's Relationship to Insured
□ Self □ Spouse □ Child □ Other

In order to control the cost of billing, we ask that the patient's portion be paid at the time services are rendered. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance.
Accounts 90 days old are subject to collection fees. There will be a $35 service charge on all returned checks.

I understand that my insurance company will be billed. Payment from my insurance is to be paid directly to Walter L. King, MD,
I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

I give permission for my medication history to be requested and viewed through electronic medical record keeping.

My signature below acknowledges that I have received a copy of Viewmont Eye Associates Notice of Privacy Practices.

Signature | _____/_____/_____ Today's Date