Roland Park Vision Services

Dr. Bruce Hyatt

409 West Coldspring Lane Baltimore, Maryland 21210 410.243.8884

Patient's Last Name _____ First _____ M.I. _____

Address _____ City_____ State _____ Zip _____

Date of Birth _____/_____/_____ Social Security # _____ Marital Status (circle) S O M O D O W O Separated O

Home Phone (_____) _____ Work Phone (_____) _____ Cellular Phone (_____) _____

Employer _____ Occupation _____ E-Mail Address _____

INSURANCE INFORMATION

Vision Insurance	**Medical Insurance**
Company:	**Company:**
Subscriber's Name:	**Subscriber's Name:**
Relationship: **D.O.B.**	**Relationship:** **D.O.B.**
Policy #:	**Policy #:**
Group #:	**Group #:**
Employer:	**Employer:**

Reason for Today's Visit (Check all that apply):

____ Routine Evaluation ____Contact Lens Evaluation ____Laser Vision Correction Evaluation ____ Screening

____ Medical Concern (please describe) _____

Do you currently wear glasses? ____ Yes ____ No Do you currently wear contacts? ____ Yes ____ No

Are you currently experiencing any vision problems? ____ Yes ____ No If you have indicated yes, please explain: _____

_____

Date of last vision exam: _____ By whom? _____

Please list any medical conditions you have: _____

_____

Please list any prescription medications and over the counter medications or supplements you take: _____

_____

Do you have any allergies? _____

I authorize **Roland Park Vision Services** to submit to my insurance company for services rendered, and request payment by my insurance company be paid directly to Roland Park Vision Services. I certify that the information I have reported is correct and authorize Roland Park Vision Services to release any necessary information to any person or entity which is or may be liable for all or a portion of my charges. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for services provided, when a statement is rendered, and that I will be responsible for any and all expenses, including collection fees and court costs associated with the collection of my account.

Signature of Patient /Parent or Guardian: _____ Date: ____/____/____