

Molalla Vision Source
Welcome To Our Office!
J. Wallace Walker, O.D. & Catherine Saul, O.D.
502 East Main St., Molalla, OR 97038
503-829-9186

Patient Information Form

Personal Information

Title: Mr. Mrs. Ms. Miss Master Today's date: _____
Full name: _____ Date of Birth: ___/___/___ Age: ____ Sex: M F
Preferred name: _____ Employer or school: _____
Billing address: _____ Spouse: _____
City: _____ State: _____ Zip: _____ E-mail address: _____
Home phone: (____) _____ Primary Care Physician: _____
Work phone: (____) _____ PCP phone number: (____) _____
Cell phone: (____) _____ Person responsible for bill: _____

Primary Insurance Information

Name of Primary Insurance Company: _____
Policy Holder's Full Name: _____ Policy Holder's Date of Birth: _____
Patient's relationship to Policy Holder: _____
Insurance Identification Number : _____ Group Number: _____

Secondary Insurance Information

Name of Secondary Insurance Company: _____
Policy Holder's Full Name: _____ Policy Holder's Date of Birth: _____
Patient's relationship to Policy Holder: _____
Insurance Identification Number: _____ Group Number: _____

INSURANCE LIABILITY STATEMENT

It is your responsibility to know your insurance company policy, your benefits, and your current eligibility for coverage at the time services are rendered by this office. It is also your responsibility to inform this office if you have changed insurance companies or benefit plans which would affect your current eligibility for coverage. If, for any reason, you are not eligible for insurance coverage at the time of your visit to our office, you will be held financially responsible for any and all services rendered. All insurance co-pays and non-covered charges are due at the time of service.

I HAVE READ THE ABOVE STATEMENT WITH FULL UNDERSTANDING OF ITS TERMS AND CONDITIONS TO WHICH I AM RESPONSIBLE.

PATIENT NAME: _____ **PATIENT SIGNATURE:** _____

