Walker Eye Care

William M. Walker, O. D.
971 S Cox St
Asheboro, NC 27203

This information will allow us to begin the process that ensures your eye health and vision remain at their best, and that your health and lifestyle needs are met. Thank you for your help.

Patients Name_____
Last First Middle Nickname

Address_____
Street or P. O. Box City State Zip

Date of Birth ____/____/_____ SS# _____ Email _____

Phone Numbers: Cell (____)_____-_____ Home (____)_____-_____ Work (____)_____-_____

Is texting okay? Yes ____ No ____ Preferred Communication Method: email ____ phone ____ mail ____

Preferred Language: English ____ Spanish ___ Gender: Female ____ Male ____

Some Ethnic groups are more at risk for eye disease. Race: _____ Ethnic Group: _____

Preferred Pharmacy_____ Pharmacy Phone Number_____

Your Employer_____ Your Occupation_____

Family Doctor_____ Doctors Phone Number_____

If married, Name of Spouse_____ Spouse's Employer_____

If under 18, Parent or Guardian's Name_____

Relationship_____ Phone (____)_____-_____ Employer _____

If student, Grade Level _____ School_____ Teacher_____

Why did you come to us?_____ Who may we thank for referring you?_____

How will you be paying today? ___ Full Payment by cash, check, or credit card ___ Insurance with copay/deductible

"I request that payment of benefits be made to the doctor or myself for any services provided. I also authorize any holder of medical information about me to release to the carrier and its agents any information needed to benefits or the payable amount for any related services."

"I understand that any services not covered by insurance and co-pays are due at the time of service."

"I also acknowledge that I have had an opportunity to receive a copy of the Privacy Practices and Policies of this office."

_____
Signature date