

# Welcome to Drs. Chandler & Timmerman's Office

Name (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Marital Status: single/ married/ divorced/ widow  
Spouse or Parents \_\_\_\_\_  
(circle)  
Emergency Name & Number \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Gender M / F  
Social Security Number \_\_\_\_\_  
Occupation \_\_\_\_\_  
Employer \_\_\_\_\_  
Business Phone \_\_\_\_\_  
Personal Physician \_\_\_\_\_  
Last Eye Doctor \_\_\_\_\_ Last Eye Exam \_\_\_\_\_  
How did you hear about this office? \_\_\_\_\_

## Insurance & Billing Information

**Vision Insurance** \_\_\_\_\_

Policy Holder's

Relation to patient (circle) self, spouse, parent

Name (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Employer \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_

**Medical Insurance** \_\_\_\_\_

Policy Holder's

Relation to patient (circle) self, spouse, parent

Name (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Employer \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_

Do you participate in a flex spending account?  Yes  No  
How will you settle your account today?  Cash  Check  Credit Card

**Payment for co-pay or any contact lens charges are due at time of service.**

*\*\* Please note that most insurances do NOT cover the Contact Lens re-evaluation or any contact lens follow-up. (VSP & EyeMed may) \*\**

## Assignment of Benefits

I hereby instruct and direct \_\_\_\_\_ Insurance Company to pay by check made out and mailed to:  
**Centerville Family Eye Care 125 E. Franklin St. Centerville, OH 45459**

Or if my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows: **c/o Centerville Family Eye Care 125 E. Franklin St. Centerville, OH 45459** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

\_\_\_\_\_  
Signature of Policyholder (or Claimant) Date