WASHINGTON EYE CARE
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Benson Chen, M.D.
Physician & Surgeon

Happy Hong, O.D.
Optometric Physician

Today's date: PCP:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Sex: ❑ M ❑ F	Date of Birth: / /
Street address:	City:		State:	Zip:
Home Phone: ( )	Cell Phone ( )	Email:	Social Security No.:	
Occupation:	Employer:		Employer phone No.: ( )	

Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan

❑ Family/Friend ❑ Proximity ❑ Website ❑ Other :

INSURANCE INFORMATION

Name of Insurance Company:	Insurance ID Number:		Insurance Group Number:	
Insurance Address:	City:	State:	Zip:	Co-payment: $

Subscriber's name:	Subscriber SS No:	Birth date: / /	Employer Name:	Employer Phone: ( )

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group No.:	Policy No.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone No.: ( )	Work phone No.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Washington Eye Care or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*