Blanchard Eye Care

Dr. Vincent M. Young, O.D.

PATIENT INSURANCE INFORMATION

Insurance Information

Primary Insurance Coverage: _____
Member Name: _____Relationship to Patient: _____
If insurance holder is different than self, please provide the policy holder's information below.
Date of Birth: _____Social Security Number: _____
Employer: _____ Daytime Phone: _____

Secondary Insurance Coverage: _____
Member Name: _____Relationship to Patient: _____
If insurance holder is different than self, please provide the policy holder's information below.
Date of Birth: _____Social Security Number: _____
Employer: _____ Daytime Phone: _____

Parental Information-This Section to be filled out ONLY if patient is under 18
(*If legal guardian is neither the mother nor the father, please inform the front desk.*)
Please fill out for all patients who are under the age of 18. The following information is necessary when filing all insurance claims for minors and will also assist us in billing the guarantor properly.

Mother's Information
Name: _____DOB: _____SSN: _____
Employer:_____ Daytime Phone: _____
Does the parent live with child? Please circle your answer Y / N *If no, please provide information below.*
Address: _____City/State/Zip: _____

Father's Information
Name: _____DOB: _____SSN: _____
Employer:_____ Daytime Phone: _____
Does the parent live with child? Please circle your answer Y / N *If no, please provide information below.*
Address: _____City/State/Zip: _____

I authorize the release of any information necessary to process insurance claims.

Patient/Guardian Signature: _____Date: _____