# MARCIA L. HUTCHEON, MD

1395 Piccard Drive, Suite 105
Rockville, MD 20850

301-977-0167

## PATIENT INFORMATION (Please answer all questions completely)

Patient Name: _____ Date of Birth_____/_____/_____ M___F___
First M.I. Last

Home Address: _____
Street (Apt. #) Town State Zip

Telephone: Cell #: ( ) _____ Home #: ( ) _____ E-mail _____
(optional)

Name of cell phone owner: _____ Relationship to patient: _____

Name of Responsible Adult _____ Adult's DOB*_____/_____/_____
First Last
* A driver's license will be requested if this information is not provided.

Person (with insurance) Occupation: _____ Employer: _____

Referring physician:_____ _____ _____
Name Town Phone # (very important)

Please list family members seen by Dr. Hutcheon: _____

## INSURANCE INFORMATION (Primary and secondary insurance information must be provided on day of visit)

| | | | |
|---|---|---|---|
| PRIMARY INSURANCE | INSURANCE COMPANY NAME | ID OR POLICY NUMBER | GROUP/CODE |
| | INSURANCE COMPANY ADDRESS | SUBSCRIBER'S SOCIAL SECURITY | DATE EFFECTIVE |
| | SUBSCRIBER'S NAME | BIRTHDAY MONTH: DAY: / | RELATIONSHIP TO PATIENT |
| | SUBSCRIBER'S ADDRESS (if different from above) | WORK PHONE (if different) | INSURANCE PHONE # |
| SECONDARY INSURANCE | INSURANCE COMPANY NAME | ID OR POLICY NUMBER | GROUP/CODE |
| | INSURANCE COMPANY ADDRESS | SUBSCRIBER'S SOCIAL SECURITY | DATE EFFECTIVE |
| | SUBSCRIBER'S NAME | BIRTHDAY MONTH: DAY: / | RELATIONSHIP TO PATIENT |
| | SUBSCRIBER'S ADDRESS (if different from above) | WORK PHONE (if different) | INSURANCE PHONE # |

Reason for visit:_____

Patient's Physician (if different from referring physician): _____

Please list any major illnesses: _____

History of prematurity? _____ If so, birth weight _____

Does patient or any blood relative have any of the following:

Blindness _____ Glaucoma _____ "Lazy Eye"_____ Wandering Eye _____ Crossed Eyes_____

Present Medications:_____

Allergies: _____

How will you be paying for the exam today? Cash _____ Check _____ Charge _____

I hereby give permission to Dr. Hutcheon to examine and treat my / my child's eyes

Signature: _____ Date: _____

IF WE ARE SUBMITTING TO INSURANCE, YOU MUST SIGN BELOW:

I authorize the release of any medical or other information necessary to process this claim. I authorize Dr. Hutcheon to apply for benefits on my behalf for services rendered and for insurance payments to be made directly to Dr. Hutcheon. I agree to reimburse Dr. Hutcheon for my copay and deductible as well as any service not covered by my medical health plan including a refraction. I understand that Dr. Hutcheon has a medical information privacy policy that will be readily available to me a the time of the visit.

Signature: _____ Date: _____