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 NC Zip

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

Cell Number (____)_____-_____ 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: (____)_____-_____

Employer: _____ Occupation: _____

Primary Doctor: _____ Doctors Phone Number: (____)_____-_____

Name of Spouse: _____ Spouse's Employer: _____

If under 18, Parent or Guardian's Name: _____ Relationship:_____

Guardian's Phone Number: (____)____-_____ Guardian's Employer: _____

Emergency Contact: _____ Phone (____)_____-_____ Relationship: _____

Did someone refer you? _____

Payment Type: ___Full Payment by cash, credit, or check ___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 for benefits or the payable amount for any related services."

" I understand that any services not covered by insurance and copays are due at the time of service"

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

Signature: _____ Date: _____