Wagner Family Eyecare
3285 State Route 257
PO Box 307
Seneca, PA 16346
www.wagnerfamilyeyecare.com

David A Wagner OD
Stephen M Reinsel OD
Phone: 814 677-6636
Fax: 814 677-9562

Patient Information

NAME:_____

DATE OF BIRTH:_____

Guarantor

person who carries the insurance

NAME:_____

DATE OF BIRTH:_____

Primary Insurance Name: _____

I request that payment of authorized benefits be made either to me or on my behalf to **David A. Wagner, O.D.** for any service furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient or Parent Signature Date

Supplemental / Secondary Insurance Info.

I request that payment of authorized Supplemental Insurance benefits be made either to me or on my behalf to **David A. Wagner, O.D.** for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to (ins. name)_____ any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient or Parent Signature Date