☐ **PARKVILLE**
8109 Harford Road
Parkville, MD 21234
410-665-1779 • Fax: 410-668-0614

☐ **PERRY HALL**
4313 Ebenezer Road
Nottingham, MD 21236
410-529-1950 • Fax: 410-529-9073

☐ **REISTERSTOWN**
106 Chartley Drive
Reisterstown, MD 21136
410-833-6622 • 410-526-9828

☐ **WESTMINSTER**
405 N. Center Street, Suite 24-A
Westminster, MD 21157
410-857-4333 • 410-857-4334

☐ **BELVEDERE SQUARE MARKET**
517 E. Belvedere Avenue
Baltimore, MD 21212
410-467-7727 • 443-835-1950

☐ **BEL AIR**
223 Brierhill Drive, Suite C
Bel Air, MD 21015
410-420-3933 • 410-420-6399

Patient Registration

Patient Name (Last, First, Middle)

Mr./Mrs./Miss/Dr.

Home Address		City, State, Zip	
Home Phone	Cell Phone Number		Work Phone
Patient's Occupation		Social Security Number	
Date of Birth	Age	Sex	Marital Status S M D W
Patient's Employer		E-mail Address	

Insurance Information

Name of Primary Insurance		Secondary Insurance	
Address		Address	
Policy Holder's Name		Policy Holder's Name	
Policy Holder's Employer		Policy Holder's Employer	
Policy Holder's Date of Birth	Sex	Policy Holder's Date of Birth	Sex
Insurance Number		Insurance Number	
Policy Holder's SS#		Policy Holder's SS#	

Patient's Authorization

I hereby authorize Levin Eye Care to apply for benefits on my behalf for covered services rendered and request that payment be made directly to Levin Eye Care. I certify that all the information in regards to my insurance is correct and further authorize the release of any necessary information for this or any related claim. I permit a copy of this authorization to be used in place of the original. I understand that I may revoke this authorization at any time in writing. I certify that all the information provided on this form is valid and will accept any and all responsibility caused by incorrect information.

Patient or Guardian Signature	Date