PATIENT INFORMATION

ADULT INFORMATION PLEASE PRINT LEGIBLY

☐ MR. ☐ MRS. ☐ MISS ☐ MS. LAST NAME, MIDDLE INITIAL FIRST NAME ☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOWED

PATIENT'S NAME : ____________________

BIRTHDATE : ____________ AGE : ________ SOC. SEC. # ____________ SEX : M F

ADDRESS : ____________________ CA DL #: ________

CITY : ____________ EMAIL ADDRESS: ____________

TELEPHONE NO. : (Home) ____________ (Cell) ____________

EMPLOYER : ____________ WORK NO.: ____________

EMPLOYER ADDRESS : ____________________

SPOUSE'S NAME : ____________ SOC. SEC. #: ____________

SPOUSE'S EMPLOYER : ____________ WORK PHONE : ____________

MINOR - CHILDREN INFORMATION PLEASE PRINT LEGIBILY

LAST NAME, MIDDLE INITIAL FIRST NAME

PATIENT'S NAME : ____________________

BIRTHDATE : ____________ AGE : ________ SOC. SEC. # ____________ SEX : M F

ADDRESS : ____________________ CA DL#: ________

CITY : ____________ STATE : ________ ZIP CODE : ________

TELEPHONE NO. : ____________________

FATHER'S NAME : ____________ SCHOOL : ____________

FATHER'S EMPLOYER : ____________ MOTHER'S NAME : ____________

MOTHER'S EMPLOYER : ____________ WORK PHONE : ____________

EMERGENCY INFORMATION PLEASE PRINT LEGIBLY

NAME OF PERSON TO CONTACT IN THE EVENT OF AN EMERGENCY : ____________

EMERGENCY CONTACT'S PHONE NUMBER : ____________

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU: ____________ PHONE: ____________

INSURANCE INFORMATION PLEASE PRINT LEGIBLY

WHO MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? ____________

NAME OF REFERRING PHYSICIAN : ____________ DRS. PHONE : ____________

NAME OF PRIMARY CARE PHYSICIAN: ____________ DRS. PHONE : ____________

PRIMARY INSURANCE PLAN OR PROGRAM NAME : ____________

SUBSCRIBER'S NAME : ____________ DATE OF BIRTH : ____________

PRIMARY INSURANCE POLICY NO.: ____________ PRIMARY GROUP NO.: ____________

SECONDARY INSURANCE PLAN OR PROGRAM NAME : ____________

SECONDARY SUBSCRIBER'S NAME : ____________ DATE OF BIRTH : ____________

DO YOU HAVE A VISION INSURANCE PLAN? IF SO, PLEASE NAME : ____________

PATIENT RELATIONSHIP TO INSURED :	PATIENT STATUS	IS PATIENTS CONDITION RELATED TO :
☐ Self ☐ Child	☐ Single ☐ Employed	EMPLOYMENT ? (CURRENT OR PREVIOUS) ☐ Yes ☐ No
☐ Spouse ☐ Other	☐ Married ☐ Full - Time Student	AUTO ACCIDENT ? ☐ Yes ☐ No
	☐ Other ☐ Part - Time Student	OTHER ACCIDENT ? ☐ Yes ☐ No

ASSIGNMENT OF BENEFITS / PATIENT'S MEDICARE AUTHORIZATION / RELEASE OF INFORMATION

ASSIGNMENT OF BENEFITS : I hereby assign all medical and / or surgical benefits, to include major medical benefits to which I am entitled, including MEDICARE, private insurance and any other health plans to: **EYE MEDICAL CLINIC OF SANTA CLARA VALLEY.**
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Additionally, I understand that routine vision screening and refractions may not be covered by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

____________________ ____________
SIGNATURE OF PATIENT OR PARENT / GUARDIAN IF A MINOR DATE