Central Valley Eye Medical Group

PATIENT INFORMATION (Please Print)

Name ______________________________ Date ______________

Date of Birth ____________ Age ______ ☐ M / ☐ F Social Security # ______________

Address ____
Street City State Zip

Phone: Home (____) ______________ Work (____) ______________

Occupation ____________________ Employer ____________________

Address ____________________________ Phone (____) ____________

Primary Care Physician ____________________ **Referring Physician** ____________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse Name ____________________________ Date of Birth ____________

Social Security# ______________ Employer ____________________________

Address ____________________________ Phone (____) ____________

Complete if under 18 years or a student

Name of Father ____________________ SS# ____________ DOB ____________

Address ____________________________ Phone (____) ____________

Employer ____________________________ Work Phone (____) ____________

Name of Mother ____________________ SS# ____________ DOB ____________

Address ____________________________ Phone (____) ____________

Employer ____________________________ Work Phone (____) ____________

INSURANCE INFORMATION

☐ Medicare # ____________________ ☐ Medi-cal # ____________________

☐ Workers Compensation (job injury) to whom is bill to be sent? ____________________

☐ Other Medical Insurance ______________________________________

Group # ____________________ ID # ____________________

Name/Address 2nd Insurance ______________________________________

Subscriber of Primary Insurance ______________________ Relationship ____________

Subscriber of Secondary Insurance ______________________ Relationship ____________

Who to notify in emergency (nearest relative or friend)?

Name ______________________________ Relationship ____________________

Home Phone: (____) ______________ Work Phone: (____) ______________

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**
2. **In Order To Control Your Cost of Billings, We Request That Your Charges For Office Visits Be Paid At The Conclusion Of Each Visit Unless You Are Covered By Medicare.**
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. 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. I hereby authorize said assignee to release all information necessary to secure the payment.
5. I understand that I must provide all pertinent information to bill my insurance company. If I neglect to provide this information I understand that I will take financial responsibility for all visits incurred.

Signed (Patient or parent if minor) ______________________ Date ______________