SLO LASIK & CATARACT

PATIENT INFORMATION:

Name:______________________________ Birth Date:____________________ Male Female

Address:______________________________ City:______________ State: ________Zip: ______________

Home Phone#:____________________ Day#:____________________ Cell#:____________________

Social Security#:__________________________ (For Billing Purposes Only—Confidential) Marital Status S M W D

Employer:________________________ Work#: ______________Occupation:_________________ Student: FT PT

Ethnicity: ☐Hispanic or Latino ☐ Non- Hispanic or Latino

Race: ☐American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Pacific Islander ☐ White ☐ Hispanic ☐Decline

E-mail: ____ **(To be enrolled in our secure electronic online Patient Portal.)**

RESPONSIBLE PARTY INFORMATION: (For Minor children or dependents)

Name:________________________________ Relationship:___________________ Birth Date:_______________

Social Security #:________________________ Employer:______________________ Phone#:_________________

For Billing Purposes Only—Confidential

Address: (if different from above)______________________________ City, State, Zip:_______________________________

INSURANCE INFORMATION: **PLEASE PROVIDE INSURANCE CARDS AT TIME OF VISIT**

☐NO INSURANCE / SELF-PAY ☐Medicare ☐Medi-Cal ☐PPO ☐HMO ☐Other:____________________

#1 Medical Insurance:__________________________ ID#:_________________________ Group:_____________

Claims Address:____ Co-Pay:____________

Subscriber:_____________________________ Subscriber Birth Date:____________________ Relation:___________

#2 Medical Insurance:__________________________ ID#:_________________________ Group:_____________

Claims Address:____ Co-Pay:____________

Subscriber:_____________________________ Subscriber Birth Date:____________________ Relation:___________

☐**Vision Insurance Plan:** _____________________________ Subscriber:_____________________________

Subscriber Birth date:______________ Subscriber Social Security#:_____________________ Relation:___________

HOW DID YOU HEAR ABOUT US?

☐PATIENT ☐RADIO ☐NEWSPAPER ☐DOCTOR ☐SIGN ☐INSURANCE ☐TV ☐INTERNET ☐OTHER _________________

Primary Care Doctor:____________________Phone#:________________Referred By:_________________________

Pharmacy: ___________________ Phone#:______________________ Address:______________________

Person to notify in case of emergency: ____________________Relation:______________ Phone#: _______________

I understand I am financially responsible for payment in full of all accounts with the exception on industrial injuries, Medi-Cal or other full sponsored government accounts. I hereby authorize my doctors to release records to other doctors or legitimate requesting sources. I authorize payment of medical benefits to my physicians or suppliers for services rendered. A photocopy of this authorization and assignment of benefits shall be as valid as the original.

________________________________ ____________________

Signature of Responsible Party Date