CALIFORNIA EYE PROfessionals Medical Group Inc

PT. # ____________
H T M

Patient Information

Name: MR. MRS. MISS MS.	FIRST	MIDDLE	LAST	Today's Date:

Home Phone:	Social Security #: - -
Work Phone:	Birth Date: / / Age:
Cell / Pager / Other:	Gender: M F
E-Mail:	Marital Status: Single Divorced Married Widowed
Address: Apt.	Occupation:
City: State: Zip:	Employer:

Emergency Contact:	Special Needs:
Phone:	☐ Hearing-impaired ☐ Wheelchair ☐ Walker ☐ Other: ___________________
Relationship to patient:	☐ Translator Language: ________________

	Patient is the policy subscriber / guarantor:
PRIMARY Insurance: ID / Policy #:	☐ Yes ☐ No
SECONDARY Insurance: ID / Policy #:	☐ Yes ☐ No
VISION / **OPTICAL** Insurance:	☐ Yes ☐ No

If policy subscriber / guarantor is other than the patient:	
Name:	Social Security #: - -
Phone:	Birth Date: / /
Relationship to patient:	Employer:

Family / Primary Physician:	Phone:
Address:	

Pharmacy:	Phone:
Address:	

- I acknowledge receipt of the "Summary of Privacy Practices" (rev. September 23, 2013) and understand that I may request to review the full-length "Notice of Privacy Practices" (rev. September 2013). _______ (initial)
- I authorize the release of any medical information necessary to process all claims. I also authorize the release of payment of medical benefits to my physician. If my insurance denies the claims, I agree to be financially responsible for my bill, and I have read and understand the "Statement of Patient Financial Responsibility" provided to me. _______ (initial)

Patient Signature: ____ **Date:** ____________________