# Lynn Eye Medical Group

2230 Lynn Road, Suite 102 • Thousand Oaks, CA 91360 • (805)495-0458 • Fax (805) 494-9630

## Patient Information *(please print)*

Name _____ Date of Birth _____/_____/_____ Sex _____

Address _____ City_____ State_____ Zip _____

Home Phone (_____) _____ Cell phone (_____) _____ E-mail _____

Social Security #_____--_____--_____ Driver's License #_____ State_____

Marital status_____ Spouse_____ Date of Birth _____/_____/_____ Referred by_____

Primary Care Physician_____ Phone (_____) _____

Employer_____ Phone (_____) _____

Emergency contact_____ Phone (_____) _____

***If the insurance information provided below is not complete and current, all visits will be considered CASH only.***

| ***Primary Insurance*** | | ***Secondary Insurance*** |
|---|---|---|
| Insurance | | Insurance |
| Subscriber / DOB | | Subscriber / DOB |
| Subscriber # | | Subscriber # |
| Member # | | Member # |
| Group # | | Group # Supplement: Yes No |

If Medicare, have you assigned your benefits to a managed care organization (HMO)? Yes No

If the policyholder is your spouse, is he/she currently employed? Yes No

Vision Plan: VSP MES Spectera Golden West Other_____

### Parent or Guardian (if child)

Name _____ Date of Birth _____/_____/_____ Relationship_____

Address _____ City_____ State_____ Zip_____

Home Phone (_____) _____ Cell phone (_____) _____ E-mail _____

Social Security #_____--_____--_____ Driver's License #_____ State_____

Employer_____ Phone (_____) _____

*I directly assign all medical/surgical benefits to Lynn Eye Medical Group (my physician) and understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize my physician to release all information necessary to secure payment of benefits. Furthermore, I authorize my physician or his representatives to obtain copies of any and/or all clinical records relevant to the pursuit of those issue(s) for which I am being seen in this office. I understand that ultimately the responsibility for adhering to the recommended treatment and follow-up plan rests with me and that this responsibility specifically shall remain with me, notwithstanding the presence or absence of insurance approved for the same.*

*I acknowledge that I read and understand the above.*

Signature of responsible party _____ Date _____/_____/_____