Miramar Eye Specialists Medical Group

2230 Lynn Road, Suite 102, Thousand Oaks, CA 91360

Patient Information *(please print)*

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

Address _____ City_____ State___ Zip _____

Home Phone (_____) _____ Cell phone (_____) _____ Marital status _____

Social Security #_____--_____--_____ E-mail_____

Driver's License #_____ State_____ 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 Ph (_____) _____ Cell Ph (_____) _____ E-mail _____

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

Employer_____ Phone (_____) _____

I directly assign all medical/surgical benefits to Miramar Eye Specialists 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 approval for the same.

I acknowledge that I have read and understand the above.

Signature of responsible party _____ Date _____/_____/_____

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