

# NEW PATIENT INFORMATION

WELCOME TO OUR OFFICE. PLEASE COMPLETE THIS FORM AND RETURN IT TO OUR RECEPTIONIST SO THAT WE MAY PREPARE YOUR CHART. THANK YOU.

## PERSONAL INFORMATION (PLEASE PRINT)

NAME \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS \_\_\_\_\_ APT. \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE: HOME ( ) \_\_\_\_\_ WORK ( ) \_\_\_\_\_

EMAIL \_\_\_\_\_

DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_ AGE \_\_\_\_\_ M/F \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

MARITAL STATUS  SINGLE  MARRIED  WIDOWED  DIVORCED

SPOUSE NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_

WORK PHONE ( ) \_\_\_\_\_

## COMPLETE IF UNDER 18 YEARS OR A STUDENT

NAME OF FATHER \_\_\_\_\_ EMPLOYER \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

NAME OF MOTHER \_\_\_\_\_ EMPLOYER \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

REFERRED BY:  FRIEND/RELATIVE  YELLOW PAGES  NEWSPAPER/FLYER  OTHER

DOCTOR \_\_\_\_\_ PHONE ( ) \_\_\_\_\_  
(NAME)

## **ALL INFORMATION BELOW MUST BE COMPLETED!!**

IF YOU ARE NOT PAYING CASH FOR TODAY'S VISIT, PLEASE PROVIDE US WITH A COPY OF YOUR MEDICAL INSURANCE CARD\*\*PLEASE NOTE THAT IF YOU HAVE VISION SERVICE PLAN (VSP), A PRE-AUTHORIZATION IS REQUIRED! IF YOU ARE BEING SEEN FOR A MEDICAL REASON AND YOU HAVE AN HMO PLAN THAT WE ARE A PROVIDER FOR, A PRE-AUTHORIZATION IS REQUIRED FOR US TO BILL YOUR INSURANCE!

ARE YOU PAYING CASH FOR TODAY'S VISIT?  YES  NO

MEDICARE? ID# \_\_\_\_\_  MEDI-CAL? ID \_\_\_\_\_

WORKERS COMPENSATION (JOB INJURY)? DATE OF INJURY \_\_\_/\_\_\_/\_\_\_

OTHER MEDICAL INSURANCE \_\_\_\_\_

INSURED'S FULL NAME: \_\_\_\_\_ INSURED'S PHONE # \_\_\_\_\_

INSURANCE CARD ID # \_\_\_\_\_ POLICY /GROUP # \_\_\_\_\_

INSURED'S DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_

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.

SIGNED (PATIENT OR PARENT IF MINOR) \_\_\_\_\_ DATE \_\_\_\_\_

REVISED 4/01

# PENINSULA LASER EYE MEDICAL GROUP