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 (____)_________________________CELL (_____)_____________________________

WORK (_____)___________________________ EMAIL ____________________________________

DATE OF BIRTH_____/_____/____ AGE______ M/F ______ SOCIAL SECURITY # __________-______-_________

OCCUPATION _____________________________ EMPLOYER ________________________________

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

SPOUSE NAME ____________________________EMPLOYER ________________________________

WORK PHONE (____) _________________________ CELL (_____)____________________________

COMPLETE IF UNDER 18 YEARS OR A STUDENT ** COVERED BY WHICH PARENT: Mother__ Father___******

NAME OF FATHER _________________________________EMPLOYER ___________________________

HOME ADDRESS _______________________________________PHONE (_____)___________________

NAME OF MOTHER ________________________________EMPLOYER ____________________________

HOME ADDRESS _______________________________________PHONE (_____) __________________

REFERRED BY: ☐ FRIEND/RELATIVE ☐ 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-AUTHORIZATON 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 TODAYS 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