

# VALLEY EYECARE CENTER PATIENT INFORMATION

*Thank you for choosing our practice for your eye care. Please complete the following information*

Today's Date \_\_\_\_\_ Do you prefer to be seen in Pleasanton or Livermore? \_\_\_\_\_

Are you | Minor | Single | Married | Divorced | Widowed Sex: | Male | Female Work Related Injury | Yes | No

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address \_\_\_\_\_  
First MI Last City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Fax Number \_\_\_\_\_

Social Security No. \_\_\_\_\_ Driver's License No. \_\_\_\_\_ Email Address \_\_\_\_\_

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ Work phone \_\_\_\_\_

If patient is a minor: Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Name of person responsible for this account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Work phone \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Address \_\_\_\_\_

Who may we thank for referring you to our practice \_\_\_\_\_ Has anyone in your family been  
or how did you hear about us? \_\_\_\_\_ our patient? Who? \_\_\_\_\_

**PRIMARY INSURANCE** \_\_\_\_\_ | HMO | POS | PPO | Indemnity | Medicare

Policyholder Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_ Employer # \_\_\_\_\_

**SECONDARY INSURANCE** \_\_\_\_\_ | HMO | POS | PPO | Indemnity | Medicare

Policyholder Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_ Employer # \_\_\_\_\_

**Vision Insurance:** Primary Insurance Co. \_\_\_\_\_ Second Insurance Co. \_\_\_\_\_

I hereby give lifetime authorization for payment of Medicare and all insurance benefits to be made directly to Jonathan Savell, M.D., Inc., Valley EyeCare Center, and any assisting physicians, for services rendered. I give this office permission to furnish my insurance company(s) any information it may request, including copies of records. I understand that it is my responsibility to follow the guidelines and to know the coverage and benefits of my medical and vision care insurance plans. If I am a member of a managed care program, it is my responsibility to notify the office that my plan requires referrals and to obtain all referrals in advance of services rendered. I understand that I am financially responsible for any balance due on my account, for services not covered by my insurance, and for all services for which I have not obtained a valid referral. I agree to pay a fee if cancelled or rescheduled appointment is not done within 24 hours. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_