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 Gender: □ Male □ Female Work Related Injury □Yes □No

Patient's Name: _____ Date of Birth: _____
First MI Last

Address _____ City _____State _____ Zip _____

Primary Phone_____ Secondary Phone _____ Fax Number _____

Last four digits of Social Security number _____ 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 _____

Who may we thank for referring you to our practice or how did you hear about us? _____

Has anyone in your family been our patient? Who? _____

PRIMARY INSURANCE _____ □ HMO □ POS □ PPO □ Medicare

Policyholder Name _____ Date of Birth _____ Last four digits of SS#_____

Name of Employer _____Work Phone _____

Subscriber # _____ Group # _____ Employer # _____

SECONDARY INSURANCE _____ □ HMO □ POS □ PPO □ Indemnity □ Medicare

Policyholder Name _____Date of Birth _____ Last four digits of SS#_____

Name of Employer _____Work Phone _____

Subscriber # _____ Group # _____ Employer # _____

Vision Insurance: Primary/Secondary _____ Insurance ID# _____

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 _____