PATIENT INFORMATION FOR: EYE SPECIALISTS OF ESCONDIDO

Patient Name **Date of Birth** **Ethnicity**

Social Security Number Marital Status: **Single Married Divorced Widowed** Please Circle

Address City State Zip Code

Best Phone Number **Cell number**

Patient Employer Occupation Business/Work Phone #

Emergency Contact (not living with you) Full Name Telephone Number

Spouses Name: Last First MN

Spouses Employer Occupation Telephone Number

If you are covered under the policy of a spouse, partner, parent, or legal guardian, please tell us about them:

Subscriber's Name SS# Date of Birth

Address (if different from patients' City State Zip Code

Please provide an e-mail address if you would like to receive information regarding patient health (email addresses are not shared or sold)

email: _____@_____

ASSIGNMENT OF BENEFITS WITH RELEASE OF INFORMATION:

I hereby authorize EYE SPECIALISTS OF ESCONDIDO to furnish information to insurance carriers concerning my illness and treatments. I hereby assign to EYE SPECIALISTS OF ESCONDIDO all payments for medical services rendered to my dependents or myself. I understand I am responsible for any amount not covered by the insurance company.

I UNDERSTAND THAT DROPS MAY BE USED TO DILATE MY EYES AND MAY BLUR MY VISION TEMPORARILY. I WAS ADVISED TO AVOID DRIVING DURING THIS TIME OF POTENTIAL VISUAL IMPAIRMENT FOR MY OWN SAFETY.

DATE:_____

****LIFETIME PATIENT'SIGNATURE:**_____

****Lifetime patient's signature refers, only to the time that you are a patient in our office.**