

# Miramar Eye Specialists Medical Group

3085 Loma Vista Road • Ventura, CA 93003 • (805) 648-3085 & (805) 648-1825 • Fax (805) 648-7027

## Patient Information (please print)

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_  
 Address \_\_\_\_\_ Cell phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_ State \_\_\_\_\_  
 Marital status \_\_\_\_\_ Spouse \_\_\_\_\_ Birthdate \_\_\_\_\_ Referred by \_\_\_\_\_  
 Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_  
 Employer \_\_\_\_\_ Phone \_\_\_\_\_  
 Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

***If the insurance information provided is not complete and current, all visits will be considered CASH only.***

Primary Insurance	Secondary Insurance
Insurance _____	Insurance _____
Member _____	Member _____
Member # _____	Member # _____
Group # _____	Group # _____ Supplement: Yes No

If Medicare, have you assigned your benefits to a managed care organization (HMO)?    Yes    No

If the policyholder is your spouse, is he/she currently employed?    Yes    No

Vision Plan:    VSP    MES    Golden West    Other \_\_\_\_\_

### Parent or Guardian (if applicable)

**Mother's Name** \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_ State \_\_\_\_\_  
 Address/City/State/Zip Code \_\_\_\_\_  
 Employer \_\_\_\_\_ Phone \_\_\_\_\_ Occupation \_\_\_\_\_

**Father's Name** \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_ State \_\_\_\_\_  
 Address/City/State/Zip Code \_\_\_\_\_  
 Employer \_\_\_\_\_ Phone \_\_\_\_\_ Occupation \_\_\_\_\_

*I directly assign all medical/surgical benefits to Miramar Eye Specialists Medical Group (my physician) and understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize my physician to release all information necessary to secure payment of benefits. Furthermore, I authorize my physician or his representatives to obtain copies of any and/or all clinical records relevant to the pursuit of those issue(s) for which I am being seen in this office. I understand that ultimately the responsibility for adhering to the recommended treatment and follow-up plan rests with me and that this responsibility specifically shall remain with me, notwithstanding the presence or absence of insurance approval for the same. I acknowledge that I read and understand the above.*

Signature of responsible party \_\_\_\_\_ Date \_\_\_\_\_