Miramar Eye Specialists Medical Group

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

Patient Information *(please print)*

Name ____ Date of Birth _____/_____/_______ Sex ______

Address ___________________________________ City__________________ State_____ Zip ________

Home Phone (_____) _____________ Cell phone (_____) _____________ E-mail _____________________

Social Security #_______--_____--_______ Driver's License #______________________ State_______

Marital status______ Spouse____________ Date of Birth _____/_____/_______ Referred by__________

Primary Care Physician___________________________________ Phone (_____) ___________________

Employer____ Phone (_____) ___________________

Emergency contact______________________________________ Phone (_____) ___________________

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

Primary Insurance	***Secondary Insurance***
Insurance	Insurance
Subscriber / DOB	Subscriber / DOB
Subscriber #	Subscriber #
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 Spectera Golden West Other________________________________

Parent or Guardian (if child)

Name _____________________________ Date of Birth _____/_____/_______ Relationship___________

Address _______________________________ City_____________________ State_____ Zip_________

Home Phone (_____) ______________ Cell phone (_____) ______________ E-mail __________________

Social Security #_______--_____--_______ Driver's License #_____________________ State_______

Employer____ Phone (_____) _________________

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 _____/_____/_______

Rev 9/07/2010