

Patient Information Form

Title: Dr. / Mr. / Mrs. / Ms. / Master / Rev. / Judge _____	Today's date _____
Full Name _____	Status: Married / Divorced / Single / Widow(er) / Domestic Partner _____
Name you go by (if different) _____	Date of Birth _____ Age: _____ Sex: M F
Home address _____	Driver's License number _____
City _____ State _____ Zip _____	Social Security number _____
Home phone (_____) _____	Employer (or School) _____
Work phone (_____) _____	Occupation (or Grade) _____
Cell phone (_____) _____	Emergency contact name _____
E-mail address _____	Emergency contact phone (_____) _____

Name of Family Members at Home	Relationship	Age	Current Patient of Ours?	
			Y	N
			Y	N
			Y	N
			Y	N

Are you a member of Vision Service Plan (VSP) ?	Y	N	How will you settle your account today?
Do you participate in a flexible spending account ?	Y	N	<input type="checkbox"/> Check <input type="checkbox"/> Cash <input type="checkbox"/> Credit Card

Medical Insurance: _____

What type of Medical Insurance do you have? PPO POS HMO Medicare part B Other: _____

I authorize the payment of any eye care and/or medical benefits indicated above to my Doctor of Optometry. I understand that I may have co-payments and overages (costs not paid for by the eye care and/or medical plan), and I am ultimately responsible for all fees incurred.

Patient or Responsible Party's Signature: _____ Date _____

Whom may we thank for referring you to our office (if applicable)?

Family, friend, or co-worker. Who? _____

Doctor referral. Who? _____

Vision Service Plan (VSP) directory.

Medical Insurance directory. Which one? _____

Internet. Which website? _____

Other. Please specify. _____

I acknowledge that I have received a copy of the Los Angeles EyeCare~Optometry Group's *Notice of Privacy Practices*, available from our office receptionist. You can also review it on our website: www.VisionSource-LAEyeCare.com

Patient name _____ Today's Date _____

Signature of patient (or parent/guardian for minors) _____