PATIENT INFORMATION SHEET

LOCATION: (CHECK ONE) ☐ CUPERTINO ☐ LOS GATOS ☐ GOOD SAMARITAN ☐ BLOSSOM HILL
DOCTOR YOU ARE SEEING:

☐Mr. ☐Mrs. ☐Miss ☐Ms.
☐Dr ☐Jr ☐Sr _____ _____ _____
Patient Last Name | Patient First Name | MI

Address: _____
Street | Apt # | City | State | Zip

Gender
☐Male ☐Female _____ _____ _____
Home Phone | Work Phone | Cell Phone

Email: _____ Preferred Communication ☐ Home Phone ☐ Work Phone ☐ Cell

Marital Status: S M D W Date of Birth: _____ Social Security #_____

Language: ☐ ENGLISH ☐ CHINESE ☐ SPANISH
Employer: _____ ☐ RUSSIAN ☐VIETNAMESE ☐OTHER_____

Primary Care Physician: _____Referring Physician: _____
If a Physician did not refer you, please tell us how you heard about our office?
☐Insurance Carrier ☐Family or Friend ☐Web Search ☐ Other:

ACCOUNT RESPONSIBLE: (If minor or dependent) Relationship to patient: ☐ Parent ☐Spouse ☐Other: _____

Name: _____
Last | First | MI ☐Female ☐Male

INSURANCE INFORMATION
Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Other

Primary Insurance: _____ ID#:_____ Group#:_____

Subscriber Name: _____ Gender: ☐Female ☐Male DOB: _____

Effective Date: _____ Employer/School: _____

Secondary Insurance: _____ ID#:_____ Group#:_____

Subscriber Name: Gender: ☐Female ☐Male DOB:

VISION INSURANCE: ☐VSP ☐MESC ☐Eye Med ☐Other ID # _____

Subscriber Name: Gender: ☐Female ☐Male DOB:

EMERGENCY CONTACT

Name: Relationship: Phone #

PAYMENT POLICY

I consent to necessary medical care and treatment by Spectrum Eye Physicians, and assign directly all medical and surgical insurance benefits otherwise payable to me, I authorize Spectrum Eye Physicians to release all information necessary to secure payment of benefits. I agree to be responsible for all services rendered to my dependents, or myself. I agree to be responsible for all co-payments, deductibles, and non-covered services. I understand that the charge for refraction or contact lens services may not be covered benefit of my insurance, and I agree to pay personally for these charges.
Medicare beneficiaries: By signing below, I authorize Medicare payment to Spectrum Eye Physicians for services provided, and the release of any information necessary to Health Financing Administration and its agents.

Signature:_____ Date:_____