LOS ANGELES EYECARE
OPTOMETRY GROUP
MEMBER Vision Source NETWORK

Patient Information Form

Title: Dr. / Mr. / Mrs. / Ms. / Rev. / Judge

Full Name: ____

Name you go by (if different): ___________________________________

Home address: ____

City: ____________________ State: _______ Zip:_______________

Home phone: (_________)_______________________________

Work phone: (_________)_______________________________

Cell phone: (_________)_______________________________

E-mail address: ____

Today's date: ____

Status: Married / Divorced / Single / Widow(er) / Domestic Partner

Date of Birth: __________________ Age: ________ Gender: M / F

Driver's License number: __________________________________

Social Security number: __________________________________

Employer (or School): __________________________________

Occupation (or Grade): __________________________________

Emergency contact name: __________________________________

Emergency contact phone: (_________)_____________________

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

Do you have Vision Insurance? VSP / EyeMed / None / Other: ________

Do you participate in a **flexible spending account**? Y N

How will you settle your account today?

❑ Check ❑ Cash ❑ Credit Card

Medical Insurance: __________________________________ **What type?** EPO / PPO / POS / HMO / Medicare part B Other: ___________

Signature on File: I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits. I authorize release to the Centers of Medicare and any other insurance company and its agents any medical information about me needed to determine payments for related services. 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) or EyeMed Directory?
- ❑ Medical Insurance directory. Which one? ________________
- ❑ Internet. Which website? Yelp / Google / Bing / Yahoo / Facebook / Other: __________
- ❑ 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): ____

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