

# Elite Eye Care Medical Group

## PATIENT INFORMATION:

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Male Female  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Home Phone# \_\_\_\_\_ Work Phone# \_\_\_\_\_ ext \_\_\_\_\_ Cell# \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Student: Full time Part time  
Social Security # \_\_\_\_\_ Marital Status S M W D E-mail: \_\_\_\_\_  
(For reminders, special saving, and health news)

Race:  White(non-Hispanic)  Hispanic  Asian  Pacific Islander  Black or African American  American Indian/Alaskan Native

## RESPONSIBLE PARTY INFORMATION: (For Minor children or dependants)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Birth date \_\_\_\_\_  
Social Security # \_\_\_\_\_ Employer \_\_\_\_\_ Phone # \_\_\_\_\_  
For Billing Purposes Only—Confidential  
Address (if different from above) \_\_\_\_\_ City, State, Zip \_\_\_\_\_

## INSURANCE INFORMATION:

**PLEASE PROVIDE INSURANCE CARDS AT TIME OF VISIT**

NO INSURANCE / SELF-PAY  Medicare  Medi-Cal  PPO  HMO  Other \_\_\_\_\_

#1 Medical Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group: \_\_\_\_\_

Claims Address: \_\_\_\_\_ Co-Pay: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber Birth Date: \_\_\_\_\_ Relation: \_\_\_\_\_

#2 Medical Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group: \_\_\_\_\_

Claims Address: \_\_\_\_\_ Co-Pay: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber Birth Date: \_\_\_\_\_ Relation: \_\_\_\_\_

**Vision Insurance Plan:** \_\_\_\_\_ Subscriber: \_\_\_\_\_

Subscriber Birth date: \_\_\_\_\_ Subscriber Social Security #: \_\_\_\_\_ Relation: \_\_\_\_\_

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## HOW DID YOU HEAR ABOUT US?

PATIENT  RADIO  NEWSPAPER  DOCTOR  SIGN  INSURANCE CO.  TV  INTERNET  OTHER \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Pharmacy: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Address: \_\_\_\_\_

Person to notify in case of emergency (NOT LIVING WITH YOU): \_\_\_\_\_ Relation: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Address: \_\_\_\_\_

**I understand I am financially responsible for payment in full of all accounts with the exception on industrial injuries, Medi-Cal or other full sponsored government accounts. I hereby authorize my doctors to release records to other doctors or legitimate requesting sources. I authorize payment of medical benefits to my physicians or suppliers for services rendered. A photocopy of this authorization and assignment of benefits shall be as valid as the original.**

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date