445 w. poplar st.
stockton, ca 95203
phone: 209 / 465-5933
lasik: 209 / 932-0220
fax: 209 / 465-2562

Heritage Eye Associates - Patient Information Sheet

Name: Today's Date:

last first middle

Address: City: Zip:

Home Phone: ( ) - Work Phone: ( ) - ext:

Cell Phone: ( ) - Email Address:

Family & Personal History (all personal information is kept strictly confidential and private)

Sex: □ Male □ Female SSN:_____-_____-_____ DOB:_____ / _____ / _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

Patient Employer:

Employer Address: City: Zip:

Spouse's Name: Spouse's DOB:_____ / _____ / _____

Spouse's (or Subscriber's) SSN:_____-_____-_____ Spouse's Employer:

Emergency Contact - Name: Phone Number: ( ) -

Primary Care Physician:

Purpose of Your Visit

How did you hear of our office? □ Friend □ Dr. Referral □ Relative □ Advertisement □ Insurance □ Other:

Do you currently wear: □ prescribed glasses □ prescribed contact lenses

Insurance Information

Primary Insurance:

Secondary Insurance:

Information for Minors (please fill out this portion if patient is under 18 years of age.)

Father's Name: DOB: SSN:

Father's Place of Employment and Address:

Mother's Name: DOB: SSN:

Mother's Place of Employment and Address:

Authorization to Bill Insurance

I understand that my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of the HCFA form or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer of agency shown in my file. In Medicare assigned claims, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible co-insurance and non-covered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

Patient's Signature: Date: