DESERT VIEW EYE CARE

PATIENT INFORMATION

First Name_____ Last Name _____MI_____ Sex_____

SS#_____Birthdate_____Marital Status_____

Address_____City_____State_____Zip_____

Telephone: Home_____Cell_____Work_____

Email Address:_____Text Confirmation: Yes ❑ No❑

How do you prefer to be contacted _____ How did you hear about our office? _____

Employer_____Occupation_____

Hobbies_____

PARENT OR GUARDIAN INFORMATION (If minor)

Name_____Birthdate_____SS#_____

Address_____
(Street/Mailing address if different) (City) (State) (Zip)

Telephone: Home_____ Cell_____ Work_____

Employer_____Relationship to Patient_____

INSURANCE INFORMATION

Name of Policy Holder _____Birth Date _____SS#_____

Address_____City_____State_____Zip_____

Telephone: Home_____Cell_____Work_____

Primary Insurance_____ Policy ID#_____

Employer_____ Relationship to Patient _____

***INSURANCE AUTHORIZATION AND* ASSIGNENT** I AUTHORIZE TREATMENT OF THE PERSON NAMED ABOVE AND AGREE TO PAY ALL FEES & CHARGES FOR SUCH TREATMENT. I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO DESERT VIEW EYE CARE. I AUTHORIZE DESERT VIEW EYE CARE TO RELEASE ANY INFORMATION REQUIRED FOR MY INSURANCE.

HIPPA PRIVACY PRACTICES: RECEIVED❑ DECLINED ❑ DATE _____

SIGNATURE_____ PRINT NAME_____