

Conejo-Simi Eye Medical Group

2045 Royal Ave. Suite 125 • Simi Valley, CA 93065 • (805) 527-6720
 351 Rolling Oaks Dr. • Thousand Oaks, CA 91361 • (805) 497-3744

Patient Information (please print)

Name _____ Date of Birth ____/____/____ Sex _____
 Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ Cell phone (____) _____ E-mail _____
 Social Security # _____ -- _____ -- _____ Driver's License # _____ State _____
 Marital status _____ Date of Birth ____/____/____ Referred by _____
 Primary Care Physician _____ Phone (____) _____
 Employer _____ Phone (____) _____
 Emergency contact _____ Phone (____) _____

If the insurance information provided below is not complete and current, all visits will be considered CASH only.

Primary Insurance	Secondary Insurance
Insurance _____	Insurance _____
Subscriber / DOB _____	Subscriber / DOB _____
Subscriber # _____	Subscriber # _____
Member # _____	Member # _____
Group # _____	Group # _____ Supplement: Yes No

If Medicare, have you assigned your benefits to a managed care organization (HMO)? Yes No

If the policyholder is your spouse, is he/she currently employed? Yes No

Vision Plan: VSP MES Spectera Golden West Other _____

Parent or Guardian (if child)

Name _____ Date of Birth ____/____/____ Relationship _____
 Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ Cell phone (____) _____ E-mail _____
 Social Security # _____ -- _____ -- _____ Driver's License # _____ State _____
 Employer _____ Phone (____) _____

I directly assign all medical/surgical benefits to Conejo-Simi Eye Medical Group (my physician) and understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize my physician to release all information necessary to secure payment of benefits. Furthermore, I authorize my physician or his representatives to obtain copies of any and/or all clinical records relevant to the pursuit of those issue(s) for which I am being seen in this office. I understand that ultimately the responsibility for adhering to the recommended treatment and follow-up plan rests with me and that this responsibility specifically shall remain with me, notwithstanding the presence or absence of insurance approval for the same.

I acknowledge that I have read and understand the above.

Signature of responsible party _____ Date ____/____/____