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1360 E. HERNDON AVE., SUITE #201 FRESNO, CA 93720 (559)449-5050 Fax (559)432-2632

PATIENT INFORMATION FORM

Patient Name: _____
First Middle Last

Home Address: _____ Home Phone: _____

City: _____State: _____ Zip: _____

E-mail Address: _____

Social Security Number: _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Birth Date: _____ Age: _____ ☐ Male ☐ Female

If patient is a minor, name of responsible party: _____

Responsible Party Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Name of Spouse: _____ Spouse Employed by: _____

Family Physician: _____ Address: _____

City: _____State: _____ Zip: _____

In Case of Emergency, Contact: _____ Phone: _____

Who may we thank for referring you to this office?: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance Company: _____

ID No. _____ Group No.: _____ Phone No.: _____

Secondary Insurance Company: _____ ID No.: _____ Group No.: _____

Insurance Authorization and Assignment: (Please read and sign below)

I hereby authorize Lawrence Eye Associates Medical Group, Inc. DBA InSight Vision Center to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physicians(s) all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date: _____ Signature: _____