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 _____/_____/_____