CIRCLE ONE: BLOSSOM HILL CUPERTINO GOOD SAM LOS GATOS SANTA CRUZ

PATIENT INFORMATION

Name: ______________________________ Sex: M / F DOB:_____/_____/________
Last First MI

Address: ______________________________
Street Apt. # City State Zip

Phone #: ______________ #______________ #______________
(☑ preferred) ☐ Home Phone ☐ Work Phone ☐ Cell Phone

Email: ______________________ Employer: ______________________

Social Security #: ______________ Marital Status: S M W D

Primary Language: ______________ Race: (opt) ______________ Ethnicity: Hispanic / Non-Hispanic

How did you hear about us? ☐ Referred by Physician ☐ Friends/ Family ☐ In Network Provider ☐ Other

Primary Care Physician: ______________ Referring Physician: ______________

ACCOUNT RESPONSIBLE (IF MINOR OR DEPENDENT)

Name: ______________________________ Sex: M / F Relationship to patient: ______________
Last First MI

MEDICAL INSURANCE INFORMATION

Relationship to Patient: (circle one) Self Spouse Parent Other

Primary Insurance: ______________ ID #: ______________ Group #: ______________

Subscriber: ______________________________ Sex: M / F DOB: _____/_____/________

Effective Date: _____/_____/________ Employer/School: ______________________

Secondary Insurance: ______________ ID #: ______________ Group #: ______________

Subscriber: ______________________________ Sex: M / F DOB: _____/_____/________

VISION INSURANCE: ☐ VSP ☐ EyeMed ☐ MESC ☐ Other ID #: ______________

Name of Subscriber: ______________________________ Sex: M / F DOB: _____/_____/________

EMERGENCY CONTACT

Name: ______________ Relationship: ______________ Phone #: ______________

PAYMENT POLICY

I consent to necessary medical care and treatment by Spectrum Eye Physicians and assign directly all medical and surgical insurance benefits otherwise payable to me, I authorize Spectrum Eye Physicians to release all information necessary to secure payment of my benefits. I agree to be responsible for all services rendered to my dependents, or myself. I agree to be responsible for all co-payments, deductibles, and non-covered services. I understand that the charge for refraction or contact lens services may not be a covered benefit of my insurance, and I agree to pay personally for these charges.

Medicare beneficiaries: By signing below, I authorize Medicare payment to Spectrum Eye Physicians for services provided, and the release of any information necessary to Health Financing Administration and its agents.

Signature: ______________________________ Date: ______________

Acknowledgement of Receipt of Notice of Privacy Practices

Spectrum Eye Physicians, A Medical Co.

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by email at:

Email address: ________________________________

Signature: ____ Date: ________________________

Print Name: ____ Telephone: ______________________

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of a minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of a decreased patient

Name of patient: _____________________________________

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