

Silicon Valley Eye Physicians- Patient Registration

| | | | |
|-------------------|---|--------------------|--|
| Patient's Title: | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss | Evening phone | |
| First Name | | Alternate phone | |
| Middle Initial | | Cell Phone | |
| Last Name | | Social Security # | |
| Nickname | | Employer | |
| Birth Date & Sex | | Occupation | |
| Street Address | | Family/ Primary Dr | |
| City, State, Zip | | Who referred you? | |
| Drivers License # | | E-mail address | |

How did you hear about us?

Dr. Friend Family Insurance Paper Phone book Radio TV Magazine Website Employer Mailing

Medical Insurance Information

| Primary Medical Ins. | | Secondary Medical Ins | |
|-----------------------|--|-----------------------|--|
| ID Number | | ID Number | |
| Group Number | | Group Number | |
| Subscriber name | | Subscriber name | |
| Subscriber birth date | | Subscriber birth date | |
| Employer | | Employer | |

Vision Insurance Information

| Primary Vision Ins. | | Secondary Vision Ins. | |
|-----------------------|--|-----------------------|--|
| ID Number | | ID Number | |
| Group Number | | Group Number | |
| Subscriber name | | Subscriber name | |
| Subscriber birth date | | Subscriber birth date | |
| Employer | | Employer | |

Minor Patient:

I give consent and authorize Silicon Valley Eye Physicians to examine and provide treatment deemed advisable for this minor. Relationship : **[Mother, Father, Guardian]**

Insurance Authorization and Financial Agreement: I hereby authorize Silicon Valley Eye Physicians to release my diagnosis to determine the benefits payable for related services to any insurance carrier I have. I hereby authorize payment directly to Silicon Valley Eye Physicians. I understand that I am responsible for any amount not covered by insurance including deductible, coinsurance, and non-covered services. This assignment will remain in effect until revoked by me in writing. I agree it is the patient's responsibility to know which providers are in their network and which services are covered by their plan.

Privacy Notice: Review the [Notice of Privacy Practices](#) here.

BY CHECKING THIS BOX YOU ARE INDICATING THAT YOU HAVE READ THE NOTICE OF PRIVACY AND UNDERSTAND THE ABOVE STATEMENTS.