2035 Lyndell Terrace
Davis, CA 95616
530-757-6000
www.lasikbymiller.com

Please Print

Patient Information

Office Use Only: Acct# ___________ Initial: _________ Date: _________

Patient Name: ____

Last First MI

Address: ____

____

City State Zip

Home Phone: ______________________ **Work:** ______________________

Cell Phone: ______________________ **Email:** ______________________

Birth date: _______________ **Male / Female** **SS#:** ______________________

Please Circle

Patient's Occupation: _______________ **Employer:** ______________________

If Retired-previous occupation

Marital Status: ______________________ **Spouse:** ______________________

If minor, responsible party _______________ **D.O.B.**_________**Relationship** _________

Vision Insurance: ____

Name **ID#** **Group #**

Subscriber's Name: _______________ **D.O.B.:** __________ **SS#:** ______________

Medical Insurance: ____

Primary ID# Group #

____

Secondary ID# Group #

Subscriber's Name: _______________ **D.O.B.:** __________ **SS#:** ______________

Emergency Contact: ____

Name Phone

Referred By: ______________________ **Primary Care Physician:** ______________________

Co-Payments Co-Insurance and/or Deductibles for Insurance Must be Paid at Time of Service

I hereby assign all medical and/or surgical benefits, including major medical benefits, MediCare and other government sponsored programs, private insurance, and any other health plans to which I am entitled to ADVANCED VALLEY EYE ASSOCIATES, INC. This assignment will remain in effect until revoked by me in writing. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits, including MediCare under Title XVIII of the Social Security Act.

I understand that I am financially responsible for all charges whether or not paid by insurance, including any deductible amount, co-insurance, deductible, or non-covered services.

____

Signature of Patient or Guardian Date