

# East Hills Vision Care

Please take a moment to complete the following information.  
If you have any questions, please do not hesitate to ask.

Mr.  Miss  Mrs.  Ms.

Male  Female

\_\_\_\_\_  
First Name MI Last Name Preferred Name

\_\_\_\_\_  
Street Address City State Zip

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Social Security Number Date of Birth ( ) Home phone include area code ( ) Work Phone

\_\_\_\_\_  
E-mail address Guardian Person responsible for account

\_\_\_\_\_  
Emergency Contact Emergency Phone

\_\_\_\_\_  
Whom may we thank for referring you?

## Primary Insurance Information

Vision Insurance  VSP  EyeMed  Medical Eye Services  Davis  Medi-Care  Medi-Cal  Other \_\_\_\_\_

\_\_\_\_\_  
Insured's Place of Employment Name of Primary **Medical** Insurance Company

M  F  
\_\_\_\_\_  
Insured's First Name MI Insured's Last Name

\_\_\_\_\_  
Insured's Identification Number Group Number Insured's Date of Birth

**Patient Relationship to Insured**  Self  Spouse  Child  Other  
**Patient Status**  Single  Married  Other  
 Full time student  Part time student  Employed

## Secondary Insurance Information

\_\_\_\_\_  
Insured's Place of Employment Name of Primary **Medical** Insurance Company

M  F  
\_\_\_\_\_  
Insured's First Name MI Insured's Last Name

\_\_\_\_\_  
Insured's Identification Number Group Number Insured's Date of Birth

**Patient Relationship to Insured**  Self  Spouse  Child  Other

### Please read:

In order to control the cost of billing, the patient's portion must be paid at the time services are rendered. We would rather control billing costs than be forced to raise our fees. The undersigned will ultimately be responsible for any bill incurred in this office. Insurance verification is not a guarantee of payment. There will be a service charge on all returned checks.

I acknowledge that I received a copy of the Notice of Privacy Practices for this office

\_\_\_\_\_  
Signature of Patient Date