PERSONAL DATA -

Name of Patient _____ Sex _____

Age _____ Date of Birth _____ Grade/School _____

Home Address _____ Home Phone_____

City_____ State_____ ZIP_____ Cell _____

Family Physician_____

CONSULTATION REQUESTED BY –

_____

Name/Profession/Relationship

PERSON RESPONSIBLE FOR ACCOUNT – (Subscriber on Insurance)

Name _____ **Driver's Lic.No. _____**

Business Address _____ City _____ St _____ Zip _____

Business Phone _____ **Soc. Sec. #_____**

Spouse _____ Driver's Lic.No**. _____**

Business Address _____ City _____ St _____ Zip _____

Business Phone _____ Soc. Sec. #_____

Nearest Relative Not Living With You _____

Address _____ Phone _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT TO PAY PROVIDER DIRECTLY:

I hereby authorize payment directly to Saddleback Eye Medical Associates the insurance benefits to which I am entitled. I understand that I am financially responsible for charges not covered by this assignment. A photocopy of this authorization will be considered as valid as the original. I agree it is the patient's responsibility to know which providers are in their network and which services are covered by their plan.

Signature _____ Date _____

I hereby authorize Saddleback Eye Medical Associates to provide information to insurance carriers and/or referring or family physicians concerning my condition and treatments rendered. A photocopy of this authorization will be considered as valid as the original.

Signature _____ Date _____