Pendleton
EYE CENTER
A PROFESSIONAL CORPORATION

Patient Information

Name	Date of Birth		Age
Email Address	Marital Status		Sex
Address (Include APT# or PO Box#)	City	State	Zip
Drivers. Lic. #	Social Security #		
Phone #	Ethnicity		
Employer	Work #		
Spouse Name	Spouse Work #		
Emergency Contact Name	Phone #		

WHO RECOMMENDED YOU?

Friend / Relatives name	Other
Doctor's Name	Doctor's Phone #

INSURANCE INFORMATION — PRIMARY MEDICAL INSURANCE

Primary Insurance Name	ID Number
Subscriber's Name	SSN #
Subscriber's Employer	Relationship to Patient

SECONDARY MEDICAL INSURANCE

Secondary Insurance Name	ID Number
Subscriber's Name	SSN #
Subscriber's Employer	Relationship to Patient

Vision Insurance:

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Medical Information

Do you have any of the following?

☐Diabetes ☐Asthma ☐High Blood Pressure ☐Emphysema ☐Heart Disease ☐Arthritis

Other Medical Condition

List Medications

List any Eye Injuries/Surgeries

List Allergies or Reactions to Medications

Family Doctor Optometrist

Financial Assignment and Agreement — Authorization to Release

I hereby authorize the above doctor/doctors to furnish the insureds insurance company all information which said insurance company may request concerning my present claim.

Assignment of Insurance Benefit and Responsibility to Pay

I hereby assign the doctor all money to which I am entitled for expenses relative to the services performed from time to time, but not to exceed my indebtedness to said doctor. It is understood that any money, received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand there is a $50 charge for appointments canceled with less than 24 hours notice. I understand I have financially responsible to said doctor for all charges.

Patient name Patient signature Date

3637 Vista Way • Oceanside, CA 92056
Phone: 760.758.2008 • Fax: 760.758.2004 • www.PendletonEye.com