Patient Registration

Please print and fill out all information. All information is deemed private patient information and held in strict confidence.

Patient Name: _____ **Date of Birth:** ____/____/____
First M.I. Last

Address: _____ **Age:** _____ Sex: M F
Number and Street City State Zip

Patient Social Security # (REQUIRED): ____/____/____ **E-Mail:** _____@_____

Home Phone: (____)_____ **Work Phone:** (____)_____ **Cell Phone:** (____)_____

Parent(s) or Legal Guardian: _____

Occupation: _____ F/T P/T Employer: _____ Student: _____ Grade/Year: _____
School/College

Marital Status: (circle one) Single Married Divorced Widowed

Emergency Contact: _____ (____)_____
Name Address Phone Number Relationship

Referred By: : _____ OR: ☐ West Coast Magazine ☐ Internet ☐ Yellow Pages
Name

INSURANCE INFORMATION

Insured Name: _____ DOB: ____/____/____ **SS #:** ____/____/____

Vision Insurance Provider: VSP Spectera EyeMed Cigna MES DAVIS Other: _____

Health Insurance Provider: _____ ☐ HMO ☐ PPO Policy# _____

Other Family Members Seen by Dr. Gupta:

Name	Age	Name	Age

Assignment of Benefits/Release of Information: I authorize the direct payment of medical/vision benefits to the Provider of services rendered. I authorize the release of any medical information necessary to process this claim. I am financially responsible for all charges whether or not covered by insurance.. (**Please Note**: Medical related office visits are not covered by most Vision Insurances. I have read and understood the Notice of Privacy Practices.

Signature: _____ **Date:** ____/____/____

Payment is required at the time of service. Returned Checks are subject to a $25.00 Service Charge. Thank you.

I HAVE READ THE ABOVE INFORMATION AND THERE ARE NO CHANGES:

Signature	Date	Signature	Date