



Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male/Female \_\_\_\_\_
last first middle

Address \_\_\_\_\_
street city state zip code

Phone # \_\_\_\_\_ E-Mail Address \_\_\_\_\_
home work

Social Security # \_\_\_\_\_ Drivers License \_\_\_\_\_

Employer \_\_\_\_\_
company city position phone

Parent or Guardian: Name \_\_\_\_\_
last first middle phone(home & work)

Spouse Name: \_\_\_\_\_
last first middle phone(home & work)

Person Whom We May Contact In Case of An Emergency:

Name \_\_\_\_\_ Phone \_\_\_\_\_

General Physician: Name \_\_\_\_\_
city phone

Whom May We Thank For Referring You To This Office? \_\_\_\_\_

Medical and/or Vision Insurance company name \_\_\_\_\_
Please present your insurance card to the front desk

Medication Allergies:

\_\_\_\_\_
\_\_\_\_\_

I have been made aware of and have been provided information regarding the Health Insurance Portability and
Accountability Act (HIPAA). \_\_\_\_\_
Initials

I have read the explanation of insurance coverage (see back of sheet) regarding an examination for prescription of eyewear
(Refraction) and Understand that there is a separate fee for this service. Should this service not be a covered benefit
provided by my Insurance, I understand I will be responsible for the fee. \_\_\_\_\_
Initials

Assignment of Benefits:

I hereby assign medical and/or surgical benefits, to which I am entitled, including Medicare, Proviante Insurance, POS or any other
health and/or vision plan to: California Eye specialists Medical Group, Inc.

This Assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as
an original. I understand that I am financially responsible for all uncovered services and any portion my Insurance determines
is my responsibility. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_



## **Examination for Eyewear (Glasses or Contact Lens)**

### **An explanation of insurance coverage**

Medical insurance covers examinations for the diagnosis and treatment of medical eye problems. It may cover examinations for the prescription of eyewear. Some insurance plans do provide separate vision care benefits through organizations like Vision Service Plan and Medical Eye Services. Should you, at the time of your medical examination, desire the examination for eyewear and do not have the separate vision care insurance or are not covered for this benefit under your medical insurance, we will be happy to provide this service to you for a fee of \$55.00. This fee will be collected at the time of the examination.

If you have any questions regarding our eye care, our staff will be happy to assist you.