WELCOME TO CALIFORNIA VISION AND VISAGE

Today's Date

In order to serve you properly, we will need the following information. (Please print.) All information will be strictly confidentia

PATIENT INFORMATION

Legal Last Name	First	MI	AKA Name

Social Security No.	Sex	Birth Date / /	Marital Status S M W D	Driver's License No.

Residence Street Address	Apt	City	State	Zip	Country

Day Phone ( )	Evening Phone ( )	Cell Phone ( )	Pager ( )

Employer's Name	Address	City	State	Zip	Occupation

Race (optional)	Religious Preference (optional)	Place of Birth	Email

Referring Physician	Referring Physician Address	Suite	City	State	Zip

PERSON TO CONTACT IN CASE OF EMERGENCY

Last Name	First	MI	Relationship

Residence Street Address	Apt	City	State	Zip	Home Phone ( )	Business Phone ( )

Nearest Relative or Friend not living with you	Last Name	First	MI	Relationship

Residence Street	Apt	City	State	Zip	Home Phone ( )	Business Phone ( )

GUARANTOR

Last Name	First	MI	Relationship	Social Security No.	Driver's License No.

Residence Street Address	Apt	City	State	Zip	Evening Phone ( )

Employer's Name	Address	City	State	Work Phone ( )	Occupation

INSURANCE INFORMATION

PRIMARY INSURANCE	Insurance Company Name	Policy, Cert., Badge, Medicare or Medi-Cal No.	Plan	Group No.

Insurance Mailing Address	Insurance Co. Phone ( )

Medical Group Name	Medical Group Phone Number ( )	Effective Date	Subscriber's Name	Relationship

Subscriber's Residence Street Address	Apt	City	State	Zip	Subscriber's Phone ( )

Subscriber's SSN	Subscriber's DOB	Employer's Name and Address	Employer's Phone Numb ( )	Ext.

SECONDARY INSURANCE	Insurance Company Name	Policy, Cert., Badge, Medicare or Medi-Cal No.	Plan	Group No.

Insurance Mailing Address	Insurance Co. Phone ( )

Medical Group Name	Medical Group Phone Number ( )	Effective Date	Subscriber's Name	Relationship

Subscriber's Residence Street Address	Apt	City	State	Zip	Subscriber's Phone ( )

Subscriber's SSN	Subscriber's DOB	Employer's Name and Address	Employer's Phone Numb ( )	Ext.

Assignment of Benefits: I hereby authorize the doctors of California Vison and Visage to furnish information to insurance carriers
I hereby irrevocably assign to the doctors of California Vision and Visage all payments for services rendered and all major medical benefits
Consent for Treatment: I hereby authorize my consent to be treated now and in the future by the doctors of California Vision and Visage

Signature of Patient/Insured

Date