PASO ROBLES OPTOMETRIC CENTER

Patient Name:_____,_____Age _____
Last First Middle

Street Address:_____City:_____ZIP:_____
Mailing Address:_____City:_____ ZIP:_____

Primary Ph: (____)_____ Date of Birth:_____ Sex: Male / Female
Secondary Ph: (____)_____ Soc. Sec #:_____ **Marital Status:** Single
E-Mail Address:_____ Drivers Lic #:_____ Married Divorced
Primary Care Physician:_____ Widow(ed) Other
Language_____

Employer:_____Occupation:_____Student?_____
Employer Address:_____
Name of Spouse, Parents, or Guardian: _____
Employer(Spouse or Parent):_____Spouse Work Phone: (_____)_____
Emergency Contact(if other than above):_____Ph: (_____)_____or(____)_____
Referred by:_____

INSURANCE INFORMATION - PLEASE GIVE COPY OF CARD(S) TO RECEPTIONIST

VISION INSURANCE: ___VSP (Vision Service Plan) PEC Group:_____
___MESC (Medical Eye Services) ___EyeMed B/C Disc/Premier ___ Davis Vision ___Superior Vision
___Medicare ___CenCal_____ ___Other:_____
Primary Subscriber ID#_____ Policy Holder:_____
Secondary ID#:_____ Policy Holder:_____

MEDICAL INSURANCE: ___Medicare ___CenCal ___Blue Cross ___Blue Shield ___AARP
___HealthNet ___Cigna ___United Healthcare Other: _____

Policy Holder Name:_____Subscriber ID#_____Group #:_____

PLEASE READ CAREFULLY: I am aware of my HIPAA Rights to Privacy. I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released upon my insurance companies request for the purpose of health care operations, including, but not limited to, provider review functions, claims payment and quality assessment. I also understand that I may revoke this consent by written request at any time with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent. I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. I also understand that my request for restriction may be denied if the information restricted is required by my insurance company. I have been made aware that a complete copy of my Rights to Privacy is posted and a copy is available to me upon request.

I understand that I am responsible for all charges for services provided by Paso Robles Optometric Center.
I authorize release of any medical information necessary to process my insurance claims and request payment of any benefits due to be paid directly to Romayne T. Swanson, O.D.

(Office use only)

PATIENT SIGNATURE:_____**DATE:**_____ OK_____

FOR MEDICARE PATIENTS ONLY: OK_____
If a refraction is done to check for visual changes, this is considered a non-covered service by Medicare.
You will be responsible for the fees for this service. OK_____

PATIENT SIGNATURE:_____**DATE:**_____ OK_____
Rev 3/2017