---------------WESTSIDE EYE CENTER---------------
PATIENT INFORMATION

Patient Name: please circle M / F

Responsible Party if Minor

Address: City Zip

Home Phone: Work #: Cell #: TEXT

Date of Birth: Social Security #: XXX-XX- email:

Ethnicity Race Marital Status

Employer: Occupation:

Spouse/Partner's Name:

Emergency Contact: PH#

Who may we thank for referring you to our office

Primary Insurance: ID# Group#

Subscriber's Name: Relationship to Patient: DOB:

Secondary Insurance: ID# Group#

Subscriber's Name: Relationship to Patient: DOB:

I understand and agree that regardless of my insurance status, I am responsible for the balance of my account and authorize the release of any medical information necessary to bill my insurance.

➡ *Signature of Responsible Party* Date

Notice of Privacy Practices Acknowledgement

I also understand and acknowledge that Westside Eye Center will keep records of my eye care services that are provided at this clinic. I may ask to see and copy that record. We will not disclose your information to others unless you direct us to do so or unless the law authorizes us to do so. Our "Notice of Privacy Practices" handout (available upon request) describes in more detail how your health information may be used and disclosed and how you can access your information.

By my signature below, I acknowledge the "Notice of Privacy Practices" information as described.

➡ Signature of Responsible Party Date