

CONEJO FAMILY EYECARE / Drs. Griffith and Hamlet, Optometrists
 299 W. Hillcrest Drive, Suite 215, Thousand Oaks, California 91360 Tel: 805-497-6964

Patient Information

Today's Date: _____

Please circle title: Mr. Mrs. Ms. Miss. Dr.			Nickname:	
Last,	First	Middle Initial	Date of Birth:	Age
Address			Social Security #	
Address			Marital Status	
City	State	Zip	Employer/ School	
Home Phone			Occupation	
Daytime / Cell Phone			Whom may we thank for referring you?	
E-mail				

Insurance Information

Person Responsible for Account (if different than patient):

Last,	First	Date of Birth:
Address		Social Security #/ Subscriber ID
Address		Relationship to Patient:
City	State	Zip
Home Phone		Occupation
Daytime Phone		
Insurance Company:		
Please Circle: VSP Davis Vision Health Net MES Blue Cross Medicare Other: _____		

Authorizations/Acknowledgement of Receipt of Privacy Practices

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance/Medicare benefits, and I authorize payment of these benefits directly to Drs. Griffith and Hamlet, Optometrists for any services and materials furnished. If I have other health insurance coverage, my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent. If needed, I authorize any holder of medical information about me to release to my insurer/the Centers for Medicare any information needed to determine these benefits payable to related services. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the use of this signature on all insurance submissions.

Furthermore, I acknowledge that I have received the Notice of Privacy Practices of Drs. Griffith and Hamlet, Optometrists.

Signature: _____ **Date:** _____