Scripps Poway Eyecare

Keith Wan, O.D. Jay Mashouf, O.D. Melissa Bersamina, O.D.

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ ext. _____ Cell #: _____

E-Mail: _____

What's the best method of contacting you when ordering? □A phone call □Email □Text

Gender: □ Male □ Female Are you a full time student? □ Yes □ No

Date of Birth: _____ Age: ____ SSN#: _____ Marital Status: _____

Employer: _____ Occupation: _____

How did you hear about us; □ Insurance □Mailer □Website □Walk In □Yellow Pages Other_____

Personal Interests (hobbies, etc.): _____

Emergency Contact: _____ Phone Number(s): _____

INSURANCE INFORMATION

Vision Ins. Name: _____ Name of policy holder: _____

SSN# of policy holder: _____ Birth date of policy holder: _____

Occupation and employer of policy holder: _____

HMO / PPO (Circle)

Medical Ins. Name: _____ Name of policy holder: _____

SSN# of policy holder: _____ Birth date of policy holder: _____

Policy ID# _____

Occupation and employer of policy holder: _____

Primary Care Physician: _____ Phone #: _____

PERSONAL HEALTH HISTORY:

Medications, Vitamins or Supplements: (List all) _____

_____

Are you allergic to any medications? (List all) _____

ASSIGNMENT AND RECORDS RELEASE CONSENT

I have read and understood the Notice of Privacy Practices. I certify that my dependant or myself has insurance and assign directly to Scripps Poway Eyecare all insurance benefits, if any, otherwise payable to me for services rendered. Insurance estimates are a courtesy. **In the event that I do not have current insurance benefits or I am a cash-paying patient, I am financially responsible for all charges not paid by insurance.** I hereby authorize the doctors to release all information necessary to secure the payment of insurance benefits. I authorize this signature on all insurance submissions. I give consent to Scripps Poway Eyecare to release any medical records for the above-specified individual to the insurance provider and/or co-managed practitioner if necessary.

Signature: _____ Date: _____ Relationship to patient: _____