Eye Associates of San Diego

Lawrence S. Rice, M. D.
Jeffrey P. Wasserstrom, M. D.
Eye Physicians and Surgeons

Date_____ **Referred By**_____

Name:_____**Sex: M**____**F**___
Last **First** **Middle**

Address:_____
Street **City** **State** **Zip**

Date of Birth:_____**Age:**_____**Marital Status**_____**SSN**_____ **E Mail:**_____

Home Phone (_____**)**_____**Work Phone (** **)**_____**Cell (** **)**_____

Occupation:_____**Employer:**_____

Name of person to notify in case of emergency:_____

Home Phone _____**Work Phone:**_____**Relationship**_____

Primary Insurance Co:_____**Insured:**_____

Secondary Insurance Co:_____**Insured:**_____

Insured's Date of Birth (If not patient)_____**Insured's SSN (If not patient)**_____

PLEASE PRESENT YOUR INSURANCE CARD AND PICTURE ID TO THE RECEPTIONIST

Primary Care Physician:_____**Phone**_____

What is the reason for your visit today? How can we help you?_____
_____

Do you wear glasses?_____**Contact Lenses?**_____**Soft**_____**Rigid**_____
Have you ever considered Laser Vision Correction?_____

This office will bill insurance companies for which we are contracted. All other services should be paid at the time the service is rendered. The undersigned accepts primary responsibility for all fees incurred. Permission for release of all medical and insurance information is granted. I authorize payment of medical benefits to the undersigned physician for services described.

I have read the above and understand it._____**Date**_____
Patient's Signature