Family EyeCare Optometry Center, PC

DR. DOUG KING

2030 Viborg Rd. Ste. 105, Solvang
TEL (805) 688-6612 FAX (805) 686-5822

PATIENT NAME **MR.** **MRS.** **MS.** **MISS** **DR.** _____
FIRST NAME **MI** **LAST NAME**

MAILING ADDRESS: _____
Address City St Zip

PHONE # (HOME) _____ (WORK) _____(EMAIL)_____

PATIENT'S DATE OF BIRTH_____ **SOCIAL SECURITY NUMBER** _____

MARITAL STATUS:_____ **SEX** _____**OCCUPATION**_____

EMPLOYER_____**WORK ADDRESS**_____

SPOUSE'S NAME_____ **PHONE #**_____

PRIMARY CARE DOCTOR_____ **PHONE #**_____

******IMPORTANT INSURANCE INFORMATION:** Please complete this part **IN ADDITION** to providing us with the card(s)

PRIMARY INSURANCE CO._____**SUBSCRIBER**_____

RELATIONSHIP TO SUBSCRIBER_____**SUBSCRIBER'S DATE OF BIRTH**_____

SECONDARY INSURANCE _____**SUBSCRIBER**_____

FOR MINORS - Name of Parent or Responsible Party_____

ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR TREATMENT:

I hereby authorize treatment, and authorize Dr. King to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to Dr. King on my behalf. I understand that I am financially responsible for all charges not covered by my insurance.

_____ _____
signature of patient (or legal guardian) date

SIGNATURE UPDATE
I hereby assign benefits to Dr. King, and authorize treatment and release of records as stated above:

_____ _____
signature date

_____ _____
signature date

_____ _____
signature date

_____ _____
signature date

_____ _____
signature date