Patient Information Sheet

Atlantis Locations:

□ Anaheim	□ Bella Terra	□ Covina	□ Downey
□ Foothill Ranch	□ Long Beach	□ Long Beach	□ Newport Beach

Patient Name: ____
First Name Middle Name Last Name

Street Address: ____

City, State, Zip: ____
City State Zip

Date of Birth: ____/____/____ SSN: ____-____-____ Gender: □ M □ F

Home, Work, Cell # ____________ | ____________ | ____________ | ____________
Home Phone Work Phone Cell Phone E-Mail

Emergency Contact: ____
Name Phone # Relationship

Referred to us by: ____

Employer: ____
Name Address

Primary Care Physician: ____
Name Address Phone #

INSURANCE INFORMATION:

Primary Ins. Group: ______________________________ Member ID#: ______________

Policy Holder: ______________________________ ____/____/____ ____-____-____
Name Date of Birth Social Security #

IPA/Medical Group: ______________________________ Group Policy#: ______________

Relationship to Patient: □ Self □ Spouse □ Parent □ Guardian/Other

Address: □ Same as patient □ Other: ______________________________

Is the patient covered by any other medical insurance policy? □ Yes □ No
If yes, name of insurance: ______________________________ Member ID#: ______________

Is the patient covered by: □ Vision Service Plan (VSP) □ Spectera □ Eye Med □ Other

Assignment and Release

I, the undersigned, certify that I (or my dependent), have insurance with ____________________. I assign directly to ATLANTIS EYECARE all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for ALL charges, whether or not paid by any insurance. I hereby authorize ATLANTIS EYECARE to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: ______________________________ Date: ______________