



**PENINSULA  
EYECARE  
MEDICAL  
ASSOCIATES**

1360 W. 6th Street  
Suite 215 (North Building)  
San Pedro, CA 90732  
(310) 547-9991  
Fax (310) 547-2389  
www.peninsulaeye.com

# CONFIDENTIAL PATIENT INFORMATION RECORD

Acct. # \_\_\_\_\_

**PLEASE BRING COMPLETED FORM TO APPOINTMENT**

APPT. \_\_\_\_\_

PATIENT \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
Last Name First Name Middle Initial

ADDRESS \_\_\_\_\_ Telephone \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-mail Address \_\_\_\_\_

Marital Status S M D W Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_

Employer name and address \_\_\_\_\_  
City Zip

Occupation \_\_\_\_\_ Business Telephone \_\_\_\_\_ Ext. \_\_\_\_\_

Name of Spouse/Parent \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Spouse/parent Driver's License # \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse/Parent Employer name and address \_\_\_\_\_  
City Zip

Spouse/Parent Business Telephone \_\_\_\_\_

Responsible Party \_\_\_\_\_ Relationship \_\_\_\_\_

Name of relative or friend in case of emergency/relationship \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
City Zip

Family Physician \_\_\_\_\_ Referred By \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Carrier \_\_\_\_\_

Insured \_\_\_\_\_ Certificate or I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

Do you have secondary insurance coverage?  Yes  No

If yes, name of carrier \_\_\_\_\_ Name of Insured \_\_\_\_\_

Certificate or I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

I hereby authorize Peninsula Eyecare Medical Associates to render whatever services deemed necessary for the care of \_\_\_\_\_ and I agree to assume all financial obligations incurred for care. You may contact my references and obtain additional credit information if necessary.

Dated \_\_\_\_\_ Patient Signature \_\_\_\_\_

Responsible Party Signature \_\_\_\_\_

(If patient is a minor, patient should sign in addition, if possible.)

ASSIGNMENT

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I hereby authorize \_\_\_\_\_ to make payments directly to Peninsula Eyecare Medical Associates for all medical and/or surgical expense benefits otherwise payable to me for their services.  
(Insurance Carrier)

Dated \_\_\_\_\_ Signature \_\_\_\_\_

OR  
Responsible  
Parent if  
Patient a  
Minor