

# WELCOME TO PACIFIC EYECARE CENTER

12461 W. Washington Blvd. Los Angeles, CA 90066

[www.pacificyecarecenter.com](http://www.pacificyecarecenter.com)

310.390.6287

Mr. / Mrs. / Miss / Ms. / Dr.

Patient's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Day # \_\_\_\_\_

Cell # \_\_\_\_\_ Do you prefer TEXT Reminders? Y / N

Email Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Drivers Lic. \_\_\_\_\_

Last 4 of Social Security # \_\_\_\_\_ (For Insurance Verification Only)

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Is anyone in your household a patient of ours? \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

We are providers for only: **Vision Service Plan (VSP), Cigna, and Medicare.**

Please indicate if you have ANY vision/ medical insurance coverage:

Vision Insurance \_\_\_\_\_ Employer \_\_\_\_\_

Primary Member's Name \_\_\_\_\_

Primary Member's DOB \_\_\_\_\_ Last 4 SSN \_\_\_\_\_

Medical Insurance \_\_\_\_\_ PPO / HMO / POS / Other

Secondary Medical Insurance \_\_\_\_\_

*It is the policy of this office that all balance due be paid at time of the services are rendered. And a minimum of 50% of you account balance be paid when a prescription is ordered with the balance due on delivery of the prescription, unless arrangements are made in advance.*