WELCOME TO PACIFIC EYECARE CENTER

12461 W. Washington Blvd. Los Angeles, CA 90066
www.pacificeyecarecenter.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.