Patient Registration

Name:_______________________________ Title (Mr. Ms. Mrs. Dr.):_________________
Address:____________________________
City:___________________ Zip: ________
Phone: Home:_________________ Cell:___________________Work:_________________
Email:____
What is your preferred method of contact? _____________________________________
Date of Birth:________________ Social Security #_________________________________
Sex (circle): M or F **Marital Status**: Single or Married

How did you hear about us?____
Preferred Pharmacy Location/Phone Number:______________________________________
Will you allow us to access your medication list online?______________________________
Primary Care Doctor Name and Phone Number:____________________________________
Following Questions Are for Insurance Quality Control Purposes (you may decline to answer)
Your Race ___________Ethnicity__________Language______________
Do you authorize our operators to speak to a household member to reschedule appointments?______

Insurance Information

Please provide your insurance card and a photo ID for your records.

Primary Insurance: ____
Policy #: ______________________________Group #:_________________________________
Subscriber Name: (if other than the patient):_______________________________________
Subscriber Date of Birth:___________Subscriber Relationship to Patient_______________

Welcome to Eye Center of La Jolla

Comprehensive Ophthalmic Medical, Surgical, and Laser Services

Insurance and Referral Office Policy

Payment is due at the time of service unless you have insurance with a company in which Dr. Alborzian is a participating provider. If your insurance requires a copayment, that amount is **due at the time of your visit**. If your insurance requires a referral or prior authorization, it is your responsibility to obtain the authorization number prior to seeing the specialist. Accepting insurance is *a service* that we provide our patients. However, insurance companies can deny payment to our office for various reasons. We will bill you directly if your insurance company has not paid on your behalf within 45 days of your visit. By signing this form you allow us to release your billing information to the insurance company in order for our office to get paid.

Refraction Charge (READ CAREFULLY)

Medical insurance plans (including Medicare) do not pay for refraction (measurement for eyeglasses). If you choose to have a measurement for glasses, there will be *an additional fee* of **$50.00** at the time of your office visit in addition to your co-pay.

I have read these policies and I accept the terms.

Signature: ____ Date: _________________