Downey Eye Clinic

Patient's Name: _____ **Date of Birth**: _____

Mailing Address: _____ **City:** _____

State: _____ **Zip:** _____ **Cell Phone**: _____ **Home Phone:** _____

Do you want to be contacted by text messaging Yes _____ **No** _____

Social Security #: _____ **Insurance**: _____

E-Mail: _____ **Employer:** _____

Race: _____ ____Decline to answer

Ethnicity: _____ ____ Decline to answer

Sex: M F **Marital Status**: M S W D **Primary Language** _____

Account Responsible : _____ **Social Security #:** _____

Account responsible DOB _____ **Phone**: _____ **Relationship** _____

Family Physician: _____ **Referred By:** _____

I, _____ hereby authorize Dr. Max Downey, Dr. Jacob Burton and/or their office staff to release any information pertaining to **appointments, test result, pick up materials** or any other issues that may arise to the following individuals:

(A) _____ Phone _____

(B) _____ Phone _____

Patient's Or Authorized Signature:

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Downey Eye Clinic.

This assignment will remain in effect until revoked by in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

I am aware that in the event of any changes on this form, it is my sole responsibility to notify this office in person.

Signature: _____ **Date:** _____