

**PACIFIC EYE SPECIALISTS**  
2300 CALIFORNIA ST., SUITE 300  
SAN FRANCISCO, CA. 94115

**LEE K. SCHWARTZ, M.D.**  
**THOMAS M. SWIFT, O.D.**  
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### PATIENT REGISTRATION

NAME \_\_\_\_\_ REFERRED BY \_\_\_\_\_  
ADDRESS \_\_\_\_\_ FAMILY PHYSICIAN \_\_\_\_\_  
CITY \_\_\_\_\_ ZIP \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ EMPLOYER ADDRESS \_\_\_\_\_  
DAYTIME PHONE \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
EMAIL ADDRESS \_\_\_\_\_  
MARITAL STATUS M S D W NAME OF SPOUSE \_\_\_\_\_ PHONE \_\_\_\_\_  
SOCIAL SECURITY \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_  
PERSON TO CONTACT IN EMERGENCY \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WK PHONE \_\_\_\_\_  
INSURANCE: PRESENT CARD TO RECEPTIONIST

Please list the subscriber of the policy if other than the patient. List your primary insurance company first, then any other coverage.

PRIMARY INSURANCE COMPANY \_\_\_\_\_ ID # \_\_\_\_\_  
MAIN SUBSCRIBER IF OTHER THAN PATIENT \_\_\_\_\_ DOB \_\_\_\_\_  
SECONDARY INSURANCE COMPANY \_\_\_\_\_ ID # \_\_\_\_\_  
MAIN SUBSCRIBER IF OTHER THAN PATIENT \_\_\_\_\_ DOB \_\_\_\_\_  
VISION INSURANCE COMPANY \_\_\_\_\_ ID # \_\_\_\_\_  
MAIN SUBSCRIBER IF OTHER THAN PATIENT \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_  
PARTY RESPONSIBLE FOR PAYMENT (if other than patient): \_\_\_\_\_  
I WILL BE PAYING TODAY BY CASH \_\_\_\_\_ CHECK \_\_\_\_\_ CREDIT CARD \_\_\_\_\_

*I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS), I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I HAVE READ ALL THE INFORMATION ON THIS SHEET AND HAVE COMPLETED THE ABOVE ANSWERS. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGE IN MY STATUS OF THE ABOVE INFORMATION.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent (if minor)

\_\_\_\_\_  
Date