LA PALMA EYE CARE CENTER
Serving our community for 26 years

Todays Date:______/_______/_______

First Name: ______________________ MI.: _______ Home Phone: ( ) -

Last Name: ____________________________ Work Phone: ( ) -

Birth Date: _______/_______/_______ *** Cell Phone: ( ) -

*** E-mail: @

Marital Status: ❒ Married ❒ Single *Sex:* ❒ M ❒ F SS#: ____________________

Address: ______________________________ City: ______________ CA Zip: ____________

Responsible Party: ❒ Self ❒ Other ________________________________

Relationship: ____________________________________ Phone: ( ) -

Address: ______________________________ City: ______________ CA Zip: ____________

Primary Insurance: ____________________________ ❒ Medicare

Subscriber Name ❒ Self ❒ Other ________________________________

Secondary Insurance: ______________________________ ❒ Medicare ❒ Medi-Cal

Subscriber Name ❒ Self ❒ Other ________________________________

Emergency contact: Name: ______________________________ Phone: ( ) -

Name of family physician: _________________________________

I authorize payment of medical benefits and release of medical information to Ilan Hartstein, M.D. inc. I agree to pay any amount approved but not paid for by my insurance eg: Co-pay, Co-insurance, non covered services, I acknowledge that I have received a copy of the notice of Privacy Practice.

____ ______/_______/______

Patient's or Authorized Person's Signature Date