VENTURA EYE INSTITUTE INC.
Michael T. Ragen, M.D.

First Name: _____ Last Name: _____

Date of Birth: _____ Male: _____ Female: _____

Social Security #: _____ Marital Status: S_____ M_____ D_____ W_____

Address: _____ Apt. #: _____

City: _____ St: _____ Zip: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Driver's Lic. #: _____ Email Address: _____

General Practitioner: (last, first) _____

City_____ Office Phone #_____

Employer: _____ Who referred you to our office? _____

Emergency Contact: (Name)_____ (Phone)_____

Financially Responsible is same as above: Yes / No (If different please fill out information below)

(Last, First): _____ Patient's relationship: _____

Address: _____ City: _____ St: _____ Zip: _____

Phone #: _____ SSN: _____ DOB: _____

Insurance Information: (Please give insurance card(s) to the receptionist to copy)

Insurance Company: _____ Insured ID #: _____

Insured Person (If Not Patient) Name:_____ DOB: _____

Financial/Insurance Agreement

By the signature below, I hereby certify the correctness of the above information and authorize release of information to my insurance company. I assign benefits to Ventura Eye Institute. A photocopy of the assignment may serve as the original. I hereby agree that in consideration for services rendered by the doctor, I shall make prompt payment to my account as bills are presented. If it becomes necessary for the account to be referred to a collective action, I shall pay the actual attorney's fees and collection expenses.

Signed: _____ _____

Patient or Responsible Party Date