

Allied Gardens Family Optometry  
5175 Waring Rd. San Diego, CA 92120  
P: (619)583-1000 F: (619)229-1938

**Insurance Information**

Patients Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

SS number \_\_\_\_\_

Name of Eye Insurance \_\_\_\_\_

Name of Medical Insurance \_\_\_\_\_

Name of Primary Insured (if not yourself) \_\_\_\_\_

Relationship \_\_\_\_\_ Insured's date of birth \_\_\_\_\_

Primary's SS number (if not yourself) \_\_\_\_\_

I authorize Dr. Monaco to release any information necessary to expedite insurance claims.  
I authorize payment to Dr. Monaco by my insurance plan. I understand that I am  
responsible for any charges not paid for by my insurance.

\_\_\_\_\_  
Signature of patient or guardian

\_\_\_\_\_  
Date