OAKLAND EYE CARE

Patient Registration

Full Name _____ What would you like to be called_____
Social Security # _____ Date of Birth ___/___/___ Age____ Sex □ Male □ Female
Home Address _____ Apt # _____
City _____ State ____ Zip _____ Email Address _____
Home Phone _____ Cell Phone _____
Employer _____ Work Phone _____
Spouse's Name _____ Date of Birth ____/____/_____

In Case of an Emergency, Contact: Name _____
Phone ( ) _____ Relationship _____

RESPONSIBLE PARTY: (if patient is under 18)
Full name _____
Relationship to Patient _____ Date of Birth ___/___/____
Home Address _____ Apt # _____
City _____ State ____ Zip _____ Home Phone_____
Cell Phone _____ Work Phone _____

HOW DID YOU HEAR ABOUT OUR OFFICE?
□ Doctor (name) _____ □ Yellow Pages _____
□ Optometrist (name) _____ □ Friend/Relative/Previous Pt.(name) _____
□ Internet (website) _____ □ Other _____

IS YOUR VISIT TODAY A WORK RELATED INJURY? □ YES □ NO
Employer Contact _____ Phone_____

INSURANCE INFORMATION:

Primary Medical Insurance
Subscriber _____
Subscriber Social Security #_____
Subscriber Date of Birth _____/_____/_____
Insurance Co. Name _____
What is your Copay _____

Secondary Medical Insurance
Subscriber _____
Subscriber Social Security #_____
Subscriber Date of Birth _____/_____/_____
Insurance Co. Name _____
What is your Copay _____

Please list your Vision Insurance
Subscriber _____
Subscriber Social Security #_____
Subscriber Date of Birth _____/_____/_____
Insurance Co. Name _____
What is your Copay _____

□ I have no secondary insurance

□ I have no vision insurance

A refraction may be done to determine your need for glasses. Without a refraction, a prescription for glasses cannot be written.
A refraction may also be necessary if you have a medical eye condition causing a vision problem. A refraction is not a covered service by Medicare or most insurance plans. Our fee for a refraction is $40.00 and is collected at the time of your service.

Signature of Patient or Guardian _____ Date_____