

Pleasanton Optometry, Inc.  
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Peter L. Miller, O.D.

1400 Santa Rita Road, Ste B  
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## Patient Registration

Welcome to Pleasanton Optometry.  
Thank you for choosing our office for your yearly comprehensive  
eye-health examination. Please fill out completely.

Today's date \_\_\_\_\_

Mr. Mrs. Miss Ms.

Patient's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Spouse/Parent \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Member's Policy # \_\_\_\_\_

Member's Employer \_\_\_\_\_

Patient's Social Security # \_\_\_\_\_

How were you referred to our office and by whom? \_\_\_\_\_

relative \_\_\_\_\_

another Dr. \_\_\_\_\_

Yellow Pages \_\_\_\_\_

friend \_\_\_\_\_

insurance list/website \_\_\_\_\_

other \_\_\_\_\_

I authorize this office to release any information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges at the time the service and materials are rendered.

Signed \_\_\_\_\_