

Pleasanton Optometry, Inc.  
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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. Dr.

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

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

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

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

Spouse/Parent \_\_\_\_\_ E-mail \_\_\_\_\_

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

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

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

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

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

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

Relative \_\_\_\_\_ Phone Book \_\_\_\_\_ another Dr. \_\_\_\_\_ Welcome Wagon \_\_\_\_\_  
Friend \_\_\_\_\_ Insurance list/website \_\_\_\_\_ other \_\_\_\_\_

If I have medical insurance or vision benefits, I authorize my plan carrier to directly pay Pleasanton Optometry. I also authorize Pleasanton Optometry to release any information required for payment to be made. **If my plan carrier does not pay, or partially pays, I understand I am responsible for the payment in full or the remaining balance.** My signature below verifies that I understand this agreement and the above financial disclaimers.

\_\_\_\_\_  
Signature of Patient if over 18 or Parent of Patient