Pleasanton Optometry, Inc.
Celia Ziel, O.D.
Peter Miller, O.D.

1400 Santa Rita Road, Ste F
Pleasanton, Ca 94566
(925) 846-4364

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 ______________________________

Vision Insurance _________________________ Who is the insured? Self Husband Wife Parent

Medical Ins, please circle: Kaiser, BlueCross, UHC, Cigna, Medicare, Other PPO __________________
We will need a copy of your medical card.

Patient's Social Security # ___________________________________

How were you referred to our office and by whom? ____

Relative _______ Insurance list______ Google____
Friend _______ Our Website______ Yelp______ other ______

Our office needs a copy of your Medical Ins. card for your record and to bill eye health visits.

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.

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Signature of Patient if over 18 or Parent of Patient