Pleasanton Optometry, Inc.
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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 _____

Work Phone (_____) _____

Vision Insurance _____ Member's Policy #_____

Medical Insurance _____ Member's Policy #_____

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 _____

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.

_____
Signature of Patient if over 18 or Parent of Patient