

WELCOME to SAN BRUNO EYE CARE CENTER

PATIENT INFORMATION			
Last Name:	First Name:	M.I.	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered for ____yrs	Birthdate	Age	Occupation
Address:	City	State	Zip Code
Work Phone ()	How did you hear about us? <input type="checkbox"/> Yellow pages <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Dr's office <input type="checkbox"/> Internet website <input type="checkbox"/> Friend		
Home Phone ()	Email:		
Cell Phone ()	If a child, parent/guardian's name:		
INSURANCE INFORMATION			
Insurance Carrier: <input type="checkbox"/> Vision Service Plan (VSP) <input type="checkbox"/> Medical Eye Services (MES) <input type="checkbox"/> Superior Vision <input type="checkbox"/> EyeMed <input type="checkbox"/> Tricare <input type="checkbox"/> MediCal <input type="checkbox"/> Other	Are you the Primary Subscriber on the insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Please indicate name of Primary Subscriber:		
	Insurance ID or SSN# of Primary subscriber	Birthdate of Primary subscriber	
	Employer of Primary subscriber		
LIFESTYLE QUESTIONS:			
Do you(Check box if your answer is yes) <input type="checkbox"/> work at a computer? How much? ____hrs/day <input type="checkbox"/> think you might benefit from thinner, lighter lenses? <input type="checkbox"/> have prescription sunwear? <input type="checkbox"/> Do you play sports? <input type="checkbox"/> golf <input type="checkbox"/> biking <input type="checkbox"/> baseball <input type="checkbox"/> basketball <input type="checkbox"/> swimming <input type="checkbox"/> other _____ <input type="checkbox"/> want information on lasik? <input type="checkbox"/> have problems with glare at the computer screen or driving at night? Please indicate any hobbies _____	Last Eye Examination: _____ Name of previous eye Dr. _____ Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> All the time <input type="checkbox"/> Reading/Computer <input type="checkbox"/> Occasionally <input type="checkbox"/> Driving /TV Do you have more than one pair of glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you interested trying new/switching contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No Type of contact lenses worn currently: <input type="checkbox"/> Soft Disposable <input type="checkbox"/> Astigmatism <input type="checkbox"/> Gas Permeable/Hard What brand of are your contacts? <input type="checkbox"/> Acuvue <input type="checkbox"/> Bausch & Lomb <input type="checkbox"/> Coopervision <input type="checkbox"/> Other _____		
ACKNOWLEDGEMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES			
We are required to provide you a copy of our Notice of Privay Practices, which states how we may use and/or disclose your health information. Your signature on this form acknowledges your receipt of the Notice.			
<i>Patient/Guardian signature</i> _____			
<i>Date</i> _____			
The above information is true to the best of my knowledge. I understand that I am financially responsible for co-payments at the time of services. I also authorize San Bruno Eye Care Center or insurance company to release any information required to process my claims. Charges that are not a benefit or, or not authorized by my health plan are also my financial responsibility. The balance must be paid in full before release of eyewear or contact lenses.			
<i>Patient/Guardian signature</i> _____ <i>Date</i> _____			