WELCOME to SAN BRUNO EYE CARE CENTER

PATIENT INFORMATION

Last Name:	First Name:	M.I.	Sex: ☐Male ☐Female
☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced ☐Partnered for____yrs	Birthdate	Age	Occupation
Address:	City	State	Zip Code
Work Phone ( )	How did you hear about us? ☐Yellow pages ☐Insurance Plan ☐Dr's office ☐ Internet website_____ ☐Friend_____		
Home Phone ( )	Email:		
Cell Phone ( )	If a child, parent/guardian's name:		

INSURANCE INFORMATION

Insurance Carrier: ☐ Vision Service Plan (VSP) ☐ Medical Eye Services (MES) ☐ Superior Vision ☐ EyeMed ☐ Tricare ☐ MediCal ☐ Other_____	Are you the Primary Subscriber on the insurance? ☐Yes ☐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)

☐ work at a computer? How much? ____hrs/day
☐ think you might benefit from thinner, lighter lenses?
☐ have prescription sunwear?
☐ Do you play sports?
☐golf ☐ biking ☐baseball ☐basketball
☐ swimming ☐other_____
☐ want information on lasik?
☐ 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? ☐Yes ☐ No
☐All the time ☐Reading/Computer ☐Occasionally
☐Driving /TV

Do you have more than one pair of glasses? ☐ Yes ☐ No
Do you wear contact lenses? ☐Yes ☐ No
Are you interested trying new/switching contact lenses?
☐Yes ☐ No
Type of contact lenses worn currently:
☐ Soft Disposable ☐ Astigmatism ☐ Gas Permeable/Hard
What brand of are your contacts?
☐Acuvue ☐Bausch & Lomb ☐Coopervision
☐Other_____

ACKNOWLEDGEMENT RECEIPT OF NOTICE OF PRIAVACY 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.

Patient/Guardian signature_____

*Date*_____

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.

Patient/Guardian signature_____ *Date*_____