OLD TOWN TUSTIN EYECARE

Optometrists:
Dr. Darren Brown
Dr. Susan Brown
Dr. Joy Coloma
Dr. Sarah Onaga

Welcome To Our Office.
Thank You For Selecting Our Office For Your Visual Needs.

MARRIED SINGLE DIVORCED WIDOWED MALE FEMALE TODAY'S DATE_____, 20____

PATIENT (PRINT) _____ BIRTHDATE _____/_____/_____
Last First Middle

HOME ADDRESS _____ HOME PHONE (____)_____
Street Address City State Zipcode

_____ CELL PHONE (____)_____
Email Address Social Security #

PATIENT EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ (____)_____
Street Address City State Zipcode Phone #

IF STUDENT, NAME OF SCHOOL, GRADE, AND MAJOR _____

DATE OF LAST VISUAL EXAM _____ DR._____CITY _____

CHILDREN'S NAMES W/ AGES (IF MINORS) _____, _____, _____

NAME OF SPOUSE _____ BIRTHDATE _____/_____/_____

EMPLOYED BY _____ OCCUPATION _____ BUSINESS PH# (____)_____

DO YOU WEAR CONTACT LENSES NOW? Yes No IF YES, WHEN WERE THEY PRESCRIBED? _____

ARE YOU INTERESTED IN LEARNING MORE ABOUT THE LATEST ADVANCES IN: CONTACT LENSES? Yes No LASER SURGERY? Yes No

PRIMARY INSURANCE INFORMATION

Insured Name:_____ Social Security # _____ DOB _____

Insurance Company:_____Insured Employer: _____

SECONDARY INSURANCE INFORMATION

Insured Name:_____ Social Security # _____ DOB _____

InsuranceCompany:_____Insured Employer: _____

WHOM MAY WE THANK FOR YOUR REFERRAL? _____

ASSIGNMENT OF BENEFITS/RELEASE INFORMATION: I authorize the direct payment of medical benefits to the Provider for services rendered. I authorized the release of any medical information necessary to process this claim. I understand that payment is required at the time of service unless prior arrangement has been made.

Signature _____

PLEASE PROVIDE THE FOLLOWING INFORMATION SO WE MAY SEE YOU MORE EFFICIENTLY.

Do you or any of your relatives have any of the following conditions that can affect the eyes (please circle):

Asthma	Self	Relative (specify):_____	Cataracts	Self	Relative (specify):_____
Diabetes	Self	Relative (specify):_____	Glaucoma	Self	Relative (specify):_____
High Blood Pressure	Self	Relative (specify):_____	Macular Degeneration	Self	Relative (specify):_____

Other Health Issues (specify): _____ Other Eye Issues (specify): _____

Medications: _____ **Allergies:** _____