PRO OPTICAL PATIENT REGISTRATION FORM

JEFFREY KUBLIN, O.D. CHERYL DEPAOLO JOST, O.D. BAO-KIM NGUYEN, O.D. SUSAN CHENG, O.D

Legal Name _____ _____ _____
Mr. Mrs. Ms. Dr. Fr. (Circle one) First MI Last

Address _____ **City** _____ **State** _____ **Zip** _____

Gender: ☐ Male ☐ Female **Birth Date**: ____/____/_____ Age**:** **Last 4 of Social Security #:** _____
Month Day Year

Home Phone (____**)**_____ **Work Phone (**_____**)**_____ **Cell Phone (**_____**)**_____ ☐ **Text Ok**

Email address _____

Employer_____ **Type of work you do** _____

Emergency contact_____**Relationship**_____**Phone** (___) _____

Health Insurance_____ **Policy Number**_____

Vision Coverage (if applicable) ☐ VSP ☐ EyeMed ☐ Davis Vision **Policy Number**_____
Member ID Number

Primary Care Doctor _____ **Phone Number**_____

Primary Reason for Visit_____ **Last Eye Exam** _____

I'm interested in learning about: Computer Glasses Polarized Sunglasses Progressive lenses Contact lenses

Do you currently wear eyeglasses? (circle one)	Yes	No	Distance	Reading		Bifocal
Do you currently wear contact lenses? (circle one)	Yes	No	Gas Perm. Daily Wear	Hard Extended Wear	Soft	Disposable

Allergies:_____

Current Eye Medication(s):_____

Family History of Eye Disease:_____

General Medical History: _____

Current General Medication(s): _____

CONTACT LENS FEES Most insurance carriers will not cover procedures related to contact lenses unless they are medically necessary. Most contact lenses are for cosmetic purposes. Please ask us for a quote of these additional fees.

ASSIGNMENT OF BENEFITS I request that payment of authorized Medicare or other assigned insurance be made directly to Pro Optical / Jeffrey Kublin, O.D / Cheryl DePaolo Jost, O.D./ Bao-Kim Nguyen, O.D./ Susan Cheng O.D. any services rendered. I authorize this holder of medical information about me to release to CMS and agents and information to determine these benefits payable for related services.
Referral: If a referral is required through your insurance, it is the patient's responsibility to obtain the referral.

I understand that I am responsible for any non-covered services.

Signature of Patient X _____ Date _____
(Parent / guardian, if under 18)

If patient is under 18 years of age, guarantor (person responsible for payment) is:_____

H.I.P.A.A / NOTICE OF PRIVACY PRACTICES
I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

Signature of Patient X_____ Date_____
(Parent / guardian, if under 18)