Alameda **O**ptometric **G**roup

Welcome to Our Office

Patient Information

- ❑ Mr.
- ❑ Mrs. _____ _____
- ❑ Ms. First/Middle/Last (as shown on insurance card) Preferred Name
- ❑ Dr.

Date of Birth: _____/_____/_____ □ Female □ Male

Address: _____ City: _____ State: ____ Zip: _____

Social Security # (last 4 digits only): _____ Email Address: _____

Phone #: _____ _____ _____
Home Work Cell

Preferred Method of Communication: (check one) □ Phone □ Email □ Text □ Postal

Occupation**:** _____ **Employer:** _____

Spouse's/Parent's Name: _____

Referred by: _____ Send a thank you note? □ Yes □ No

Primary Vision Insurance □ **VSP** □ **EyeMed** □ **MES** □ **Other** _____

Who is the Policy Holder? □ Self □ Spouse □ Child □ Domestic Partner □ Other _____

Insured's Name/DOB (if different from patient): _____
Social Security # (last 4 digits only): _____ (Name and DOB exactly as shown on insurance card)

Patient's Status: □ Single □ Married □ Widowed □ Child □ Full-time Student

Secondary Vision Insurance □ **VSP** □ **EyeMed** □ **MES** □ **Other** _____

Who is the Policy Holder? □ Self □ Spouse □ Child □ Domestic Partner □ Other _____

Insured's Name/DOB(if different from patient): _____
Social Security # (last 4 digits only): _____ (Name and DOB exactly as shown on insurance card)

Primary Medical Insurance

- Please provide insurance card(s) to the Front Desk upon your arrival.

IMPORTANT, PLEASE READ: Regarding Insurance: We do not participate in all Vision or Medical plans. It is your responsibility to provide us with your insurance information when you make the appointment. Most insurance companies require pre-authorization. We try to obtain this information prior to your arrival. If you do not provide this information, you are responsible for all fees, deductibles, co-pays and any extras not covered by your insurance. All payments are due at the time of your appointment. We do not bill or mail statements on a regular basis. We accept cash, checks, Visa, MasterCard, Discover and Debit cards.

Signature:_____Date _____