San Ramon Family Optometry

175 Market Place

San Ramon, CA 94583

925-275-0202

**New Patient Registration**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Name** |  | | | | **Nickname** | | | |  | |
| **Date of Birth** |  | | | | **Age** | | |  | **Gender** |  |
| **S S #** |  | | **Primary Language** | | | |  | | | |
| **Address** |  | | | | | | | | | |
| **Address Type** (circle) | | Home Work Other | | | | | | | | |
| **Occupation** |  | | | **Employer** | |  | | | | |
| **For the Healthcare Initiative Meaningful Use, we must ask the following:** | | | | | | | | | | |
| **Race:** [ ]American Indian/Alaska Native [ ]Asian [ ]African American [ ]Pacific Islander [ ]White [ ] Other  **Ethnicity:** [ ]Non-Hispanic/Latino [ ]Hispanic/Latino [ ]Unknown [ ]Decline to Answer | | | | | | | | | | |

**Communication** (confirming appointments, etc.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Preference**(circle all) | Home Phone Work Phone Cell Phone Email Text | | | | |
| **Home Phone #** |  | **Work Phone #** |  | **Extension** |  |
| **Cell Phone #** |  | | | | |
| **Email** |  | | | | |

**Vision Insurance**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of Insurance** |  | | | | | | | |
| **Subscriber’s Name** (if not self) | | |  | | **Relationship** | | |  |
| **Subscriber’s Date of Birth** | |  | | | **S S #** | |  | |
| Address |  | | | | | | | |
| Home Phone# |  | | | Work Phone# | |  | | |
| Cell Phone # |  | | | Email | |  | | |
| Is this person a patient in our office? [ ]Yes [ ]No | | | | | | | | |

**Medical Insurance** (not Vision Insurance)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of Insurance** |  | | | | | | | | |
| **Subscriber’s Name** (if not self) | | |  | | **Relationship** | | |  | |
| **Subscriber’s Date of Birth** | |  | | | **S S #** | |  | |
| Address |  | | | | | | | | |
| Home Phone# |  | | | Work Phone# | |  | | | |
| Cell Phone # |  | | | Email | |  | | | |
| Is this person a patient in our office? [ ]Yes [ ]No | | | | | | | | | |

**Emergency Contact**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Relationship** |  |
| **Phone** |  | **Email** |  |

**Who may we thank for referring you to our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have a Health/Flex Savings Account through your employer? [ ]Yes [ ]No**