

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: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other			
Ethnicity: <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Unknown <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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