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 Suite 400
 Glendale, CA 91203
 Ph: (818) 956-1010
 Fax: (818) 543-6083



14124 Foothill Blvd.
 Sylmar, CA 91342
 Ph: (818) 364-8181
 Fax: (818) 550-8656

PATIENT INFORMATION

LAST NAME MR. MRS. MISS	FIRST NAME	INITIAL	TODAY'S DATE			
STREET ADDRESS			FAMILY PHYSICIAN			
CITY	STATE	ZIP CODE	ADDRESS	PHONE		
HOME PHONE () () ()	WORK PHONE () () ()	CELL PHONE () () ()	RESPONSIBLE PARTY IF OTHER THAN PATIENT	PHONE NUMBER		
E-MAIL			RELATIONSHIP			
SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS S M W D		RESPONSIBLE PARTY'S ADDRESS			
SOCIAL SECURITY NUMBER	MOTHER'S MAIDEN NAME		CITY	STATE ZIP CODE		
DATE OF BIRTH MO. DAY YEAR AGE:			MEDICARE	MEDICARE NUMBER		
HOW DID YOU HEAR ABOUT US: (CHECK ONE) <input type="checkbox"/> Personal recommendation: <input type="checkbox"/> a friend <input type="checkbox"/> my family <input type="checkbox"/> a co-worker <input type="checkbox"/> Referral name _____ <input type="checkbox"/> Medical recommendation <input type="checkbox"/> medical doctor <input type="checkbox"/> optometrist <input type="checkbox"/> hospital <input type="checkbox"/> Name _____ <input type="checkbox"/> Address _____ <input type="checkbox"/> Insurance Plan Listing <input type="checkbox"/> Glendale Eye Community Health Screening <input type="checkbox"/> Yellow pages <input type="checkbox"/> Other _____			<input type="checkbox"/> YES <input type="checkbox"/> NO			
			MEDI-CAL		MEDI-CAL NUMBER	
			<input type="checkbox"/> YES <input type="checkbox"/> NO			
			PRIMARY INSURANCE COMPANY	GROUP NUMBER	MEMBERSHIP NUMBER	
			SECONDARY INSURANCE COMPANY	GROUP NUMBER	MEMBERSHIP NUMBER	
			Please provide insurance card(s) and driver's license to receptionist for photocopying. If you do not have a driver's license, 2 forms of non-photo ID are acceptable. This patient information sheet is compliant with the HIPAA Federal/State Breach Notification requirements.			
NAME OF EMPLOYER			NAME OF SPOUSE			
ADDRESS			PHONE NUMBER () ()			
CITY	STATE	ZIP CODE	CONTACT PERSON IN CASE OF EMERGENCY			
OCCUPATION			PHONE NUMBER () ()			

THE DILATING DROPS USED IN YOUR EYES AS PART OF THE EXAMINATION CAN BLUR YOUR VISION AND MAKE IT UNSAFE TO DRIVE. PLEASE DO NOT ATTEMPT TO DRIVE UNTIL YOU ARE CERTAIN THE EFFECT OF THE MEDICINE HAS WORN OFF. THE EFFECT OF THE DROPS CAN LAST UP TO FOUR HOURS.

IT IS CUSTOMARY TO PAY FOR PROFESSIONAL SERVICES WHEN RENDERED.

X _____
 PATIENT OR GUARANTOR SIGNATURE