Fremont Eye Care Physicians

Vincent L. Ray, M.D.

Steven C. Andersen, M.D.

~~Eye PHYSICIANS AND SURGEONS~~

38707 Stivers St

Fremont, CA 94536

PATIENT **INFORMATION**

PLEASE PRINT

☐ MR.

☐

Date of Birth _____

Age

NAME OF PATIENT

MRS. _____

Driver's License # _____

☐

☐ ☐ ☐

Home Address _____ Phone _____

City State Zip

Status : ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow/Widower ☐ Minor

MISS
MS.

Employed by _____ Phone _____

Work Address _____ Occupation _____

City

Spouse or Parent _____ Date of Birth _____

First Middle Last

Employed by _____ Occupation _____

Work Address _____ Phone _____

City

Name of person to notify in an emergency _____ Relationship to Patient _____

Address _____ Phone _____

City State Zip

Medical Physician _____ Phone _____

Name Address

Optometrist _____ Phone _____

Name Address

Whom may we thank for referring you? _____

Reason for visit? _____

RESPONSIBLE PARTY FOR PAYMENT

☐ SELF

☐ NAME _____ Social Security # _____

First Middle Last

Home Address _____ Phone _____

City State Zip

Employed by _____ Date of Birth _____

Work Address _____ Phone _____

City

INSURANCE (please present cards) **ID #** **Group #**

☐ Private

☐ Medicare

☐ Other _____

I understand that I will be responsible for payment for any services provided which are not covered by my insurance company or **if proper authorization has not been obtained at the time of service.**

_____ _____

Date

Signature of Patient

Fremont Eye Care Physicians
Vincent L. Ray, M.D.
Steven C. Andersen, M.D.

(Please turn over)

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PLEASE PRINT _____

MEDICATIONS: _____

ALLERGIES:
- ☐ Penicillin
- ☐ Sulfa
- ☐ Novocain or other anesthetics
- ☐ Codeine
- ☐ Other _____

SERIOUS ILLNESSES:

_____Heart Attack
_____Angina
_____Thyroid Disorder
_____Bleeding Disorder
_____Diabetes
_____High Blood Pressure
_____Kidney Disorder
_____Nerve Disease
_____Stroke
_____Cancer
_____Lung Diseases
_____ Other (asthma, emphysema, etc.)

EYE HISTORY:

_____Cataracts
_____Previous Eye Surgery
_____Glaucoma
_____Iris (Inflammation)
_____LASIK

DOES FAMILY MEMBER HAVE:

Diabetes _____
Glaucoma _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

VINCENT L. RAY, M.D.

STEVEN C. ANDERSEN, M.D.

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Pr

Signed _____ *Date* _____

Print Name _____ *Telephone* _____

If not signed by patient, please indicate relationship:

- ☐ Parent or guardian
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient _____