Morgan Hill Eyecare Optometry

Dr. Son Nguyen, OD.
16985 Monterey Rd, Ste 318
(408) 612-4462 | morganhilleyecare.com

PATIENT REGISTRATION

Name: _____ **Date of Birth:** ____/____/____ **Age:** _____ **Gender:** O **Male** O **Female** O **Other**

Salutation: O **Mr.** O **Mrs.** O **Ms.** O **Dr.** **Social Security Last 4 digits:** _____ Ethnicity: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____ **Preferred Phone:** _____
Email: _____

Occupation: _____ **Employer:** _____
Name of Parent or Guardian (if under 18) _____

INSURANCE INFORMATION

Name of Vision Insurance Company: _____ O **HMO** O **PPO**
Name of Medical Insurance Company: _____
Medicare #: _____ **Medi-Cal #:** _____

PRIMARY ACCOUNT HOLDER

Name (Last, First): _____ **Member ID #:** _____
DOB: ____/____/____ **SSN Last 4 digits:** _____ **Relationship to Patient:** O **Self** O **Spouse** O **Child** O **Parent**

EMERGENCY CONTACT

Name: _____ **Relation:** _____ **Phone:** _____

CONSENT TO PROFESSIONAL SERVICES

I hereby authorize ***Dr. Son Nguyen, O.D.*** to render optometric services and eye care to me/to my child _____.I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I also authorize the use of this signature on all insurance submissions. I have added or corrected all of the information on this document.

Patient's Signature (Guardian's Signature if under 18) **Date**

*** Office Use Only ***

Additional Information:

NOTES:

Entered:
____/____/____

Initials: