

# Welcome to Our Office

Town Center Optometry Inc.

Harold S. Masuda, O.D. 1449 W. Beverly Blvd, Montebello, CA 90640-4156 (323) 723-3937

Appointment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Name: (please print) \_\_\_\_\_  
Last First Middle

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Male \_\_\_\_ Female \_\_\_\_ SSN: \_\_\_\_\_

Mailing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Occupation: \_\_\_\_\_ Email: \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Name of parent/guardian (if minor) \_\_\_\_\_ Relationship: \_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_ Insurance Plan Name: \_\_\_\_\_

Vision Insurance Name: \_\_\_\_\_ Member's I.D. Number: \_\_\_\_\_

Member's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Last First Middle

Member's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Member's Employer: \_\_\_\_\_

Member's Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Medi-Cal: \_\_\_Yes \_\_\_No I.D. Number: \_\_\_\_\_ Medicare: \_\_\_Yes \_\_\_No I.D. Number: \_\_\_\_\_

How did you find out about our office? (Optional) Provider listing: \_\_\_\_\_ Computer (on-line): \_\_\_\_\_ Yellow Pages: \_\_\_\_\_

Walk-in: \_\_\_\_\_ Family: \_\_\_\_\_ Friend: \_\_\_\_\_ Other: \_\_\_\_\_

## Please read:

The standard eye examination provides a prescription for eyeglasses only. For an additional payment, elective contact lenses, (which include evaluation examination, fitting and materials) may be provided.

I consent to the use, disclosure and release of my health information and medical information for purposes of treatment, payment, and healthcare Insurance processes.

## Financial Agreement

I acknowledge that payment is due at time of services are rendered and I agree that I am responsible for all fees and services rendered. I accept full responsibility for all charges and I understand that I am financially responsible for all charges whether or not covered or paid by insurance. Payment is due at the time services are rendered.

**Note:** A check that has been returned by your financial institution for insufficient funds will require paying the face amount of the check and a service charge up to \$25 for the first check and up to \$35 for each subsequent check that is returned for insufficient funds, or the maximum allowed by the law.

Glasses and/or contact lenses that are not picked up within 60 days will be returned to stock and the deposit will be forfeited.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Patient or parent signature if minor)