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)