Golden Vision Optometry

Dr. Lena B. Chang, Dr. Jennie J. Fan, Dr. Margret Yu, and Dr. Angela Tsay

Golden Vision looks forward to providing you and your family with exceptional service and care.

Patient Information

Mr. ☐ / Ms. ☐ Last Name: _____First Name: _____Initial:___

Spouse's Last Name_____Spouse's First Name_____

Name of Legal Guardian (under 18) _____

Address: _____ City: _____

State: _____ ZipCode: _____**Phone#:**_____**Text OK?** Yes ☐ No ☐

Email:_____@_____.com

Social Security#: _____ **Birth Date** _____/_____/_____
(Month) (Day) (Year)

How did you hear about us? ☐ Internet ☐ Chinese Yellow Pages ☐ Driving/Walking ☐ Yelp

☐ Friend: _____ (we will send a gift certificate to your friend)

Vision / Medical Insurance Information

Name of **Vision Insurance**: _____Member ID number:_____

Primary Member's Name: _____ Birth Date: _____/_____/_____

Member Social Security #: _____Relation to Patient:_____

Name of **Medical Insurance**:_____ID number_____

Employer_____Occupation_____

Assignment and Release

I understand that payment is due on the day of service. I authorize payment of medical benefits to the undersigned physician or supplier of services received. I understand that if my insurance fails to cover any or all services or materials received, I am fully responsible for payment.
I have received my Notice of Privacy Protection (HIPPA Notice)

Signature of Responsible Party: _____ Date: _____