Golden Vision Optometry

Dr. Lena B. Chang, Dr. Jennie J. Fan, Dr. Tammy Liu

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

Patient Information

Mr. ☐ / Ms. ☐ Last Name: _____ First Name: _____

Spouse's Last Name: _____ Spouse's First Name: _____

Name of Legal Guardian (if under 18) _____

Address: _____ City: _____

State: _____ Zip Code: _____ Cell Phone #: _____

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

How did you hear about us? ☐ Internet ☐ Insurance ☐ Google ☐ Yelp

☐ Chinese Yellow Pages ☐ Walk-In ☐ Family ☐ Friend ☐ Other: _____

☐ Family/Friend Name: _____ (we will send a $25.00 gift certificate to your friend)

Email:_____

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**:_____ ☐ HMO? or ☐ PPO?

Assignment and Release

Employer:_____ Occupation: _____

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: _____