Matthew Y. Matsuzaki, OD

Date:

PLEASE PRINT ID:

Salutation: DR. MR. MRS. MS. MISS

Last Name:

First Name: Middle Initial:

Date of Birth:

Social Security (last 4 digits):

Address: Apt:

City: Zip:

Home #: Work #:

Cell #: *___ Opt in for Text Messages

Email: *___ Opt in for Emails

*Communication Preference: ☐ Email ☐ Phone ☐ Postal

Preferred Language:

Vision Insurance:

Member Name: Date of Birth:

Member ID / Social Security (last 4 digits):

Major Medical Insurance:

☐ PPO ☐ POS ☐ HMO

Employer:

Occupation:

Referred By:

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name:

Phone:

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination.

I understand that I am financially responsible for all charges, *whether or not* paid by insurance.

Payment is due at the time services are rendered.

Signature: