Welcome To Our Office!

DIXON EYECARE ASSOCIATES

An Optometric Corporation

John G. Rosten, O.D. Doctor of Optometry

Edward P. Andersen, O.D. Doctor of Optometry

Patient's Name (Please Print) _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ SSN _____-_____-_____ Home Phone _____

Employer_____Work Phone _____

Occupation_____Cell Phone _____

Marital Status _____ Spouse's Name _____

Spouse's Employer_____

If Student, Name of School_____ Grade _____

If Child, Parent's Name(s)_____

Parent's Employer(s)_____

Approximate Date of Last Eye Exam_____ Were Glasses Prescribed? _____

Previous Eye Doctor_____

Have You Ever Worn Contact Lenses?_____ When?_____

Have You Had Laser Vision Correction (LASIK)?_____ When?_____

I Was Referred By:

□ Another Family Member: _____

□ A Friend:_____

□ A Co-Worker:_____

□ Another Doctor: _____

□ Internet / Website □ Insurance Plan

□ Telephone Book □ Location of Office

□ Other: _____

Name of Vision Plan: □ VSP □ MESC □ Other_____

Vision Plan Subscriber's Name_____ Birthdate _____ SSN_____-_____-_____

Name of Medical Insurance or Health Plan_____

Are You Covered for Medicare Benefits? □ Yes □ No

Are You Covered for Medi-Cal Benefits? □ Yes □ No

Who is Responsible for Fees Not Covered by Insurance? (Name/Telephone_____)

My Method of Payment: □ Cash / Check □ Credit Card (Visa, Mastercard, or American Express)