1100 Park Place Suite 10
San Mateo, CA 94403
Phone: (650) 212-2338

08/23/19

Welcome Form

Patient Name: (Last, First)	Nickname:
Birthdate: / Age:	Last 4 digits of patient SSN:
Biological Sex: Male / Female / Other:	Gender Identity:
Address:	Primary Language
City:	State, Zip
Home Phone:	Work Phone:
Cell phone:	Communication Preference: Home Work Cell Email Text
Email:	

I authorize Winking Bee Optometry to use my e-mail address for practice communications such as appointment confirmations and notification of orders.
I can opt out of email communication at any time. Winking Bee Optometry does not share, distribute, or sell any patient information.

Occupation:	How did you find Winking Bee? Whom may we thank for referring you?
Employer:	

Primary Insurance

Subscriber (if self, write self)	Last 4 digits of subscriber SSN:
Relationship to Patient:	Birthdate:
Home phone *or* Cell phone:	Email
Vision insurance: *(Circle)* VSP Other Name of other insurance:	Medical Insurance: *(circle)* PPO or HMO Name of Insurance:

Secondary Insurance

Subscriber:	Last 4 digits of subscriber SSN:
Relationship to Patient:	Birthdate:
Home phone *or* Cell phone:	Email
Vision insurance: *(Circle)* VSP Other Name of other insurance:	Medical Insurance: *(circle)* PPO or HMO Name of Insurance:

Emergency Contact

Name:	Relationship to patient:
Primary phone:	Email: