

**ARTHUR FRIEDMAN, O.D.
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909-881-2020**

**Friedman Optometry
at the Deer Creek Vision Center
7890 Haven Ave. Suite 17
Rancho Cucamonga, Ca. 91730
909-987-3330**

Ms.
Miss
Mrs.

Mr. _____
LAST NAME , FIRST NAME, MIDDLE INITIAL

DATE

ADDRESS

DATE OF BIRTH (DOB)

CITY STATE ZIP CODE

HOME PHONE NUMBER

EMAIL ADDRESS

MOBILE PHONE NUMBER

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

EMPLOYMENT STATUS: FULL TIME PART TIME UNEMPLOYED STUDENT RETIRED

PREFERRED LANGUAGE: ENGLISH SPANISH OTHER: _____

PREFERRED METHOD OF CONTACT: MOBILE PHONE HOME PHONE EMAIL TEXT POSTCARD

VISION INSURANCE: _____

Member Name Member ID# Member DOB
MEDICAL INSURANCE: _____

Member Name Member ID# Member DOB

MEDI-CAL YES NO **MEDI-CARE** YES NO

IS THIS YOUR FIRST VISIT TO OUR OFFICE? YES NO

HOW DID YOU HEAR ABOUT US?

WEBSITE NEWSPAPER FRIEND/FAMILY REFERRING DOCTOR INSURANCE LIST OTHER

*** PLEASE TURN OFF PAGERS AND CELL PHONES DURING EYE EXAM ***

PAYMENT POLICY
ALL SERVICES MUST BE PAID FOR IN FULL WHEN RENDERED. MINIMUM DEPOSIT REQUIRED WHEN
MATERIALS ARE ORDERED. MATERIALS MUST BE PAID FOR IN FULL WHEN DISPENSED. _____

FOR OFFICE USE ONLY

NEXT APPOINTMENT (FOLLOW-UP) _____

NEXT RECALL _____