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_____