



# 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

**Alex Baker, 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 \_\_\_\_\_

Vision Plan Subscriber's Birthdate \_\_\_\_\_ Subscriber's SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of Medical Insurance or Health Plan \_\_\_\_\_

Name of Primary Care Physician \_\_\_\_\_

Are You Covered for Medicare Benefits?  Yes  No

There are certain deductibles, co-payments, and limitations which apply.

Are You Covered for Medi-Cal Benefits?  Yes  No

Who is Responsible for Fees Not Covered by Insurance? \_\_\_\_\_

My Method of Payment:  Cash / Check

Credit Card (Visa, Mastercard, or American Express)