Ninh Tran, M.D. ■ Alan Susal, M.D. ■ Richard Braunstein, M.D. ■ Nary Chum, O.D.
750 El Camino Real, San Carlos, CA 94070

Patient Information

Name _____ SS # (Last 4 digits):_____

Address _____ Phone (____) _____ (home)

City _____State _____Zip _____ Phone (____) _____ (work)

Date of Birth_____ Gender ☐M ☐F Age____ Marital Status_____Phone (____) _____ (cell)

Occupation_____Primary Care Physician _____

Emergency Contact Person_____Phone _____Relation _____

How were you referred to our office _____

Primary Medical Insurance

Insurance Company _____ Subscriber# _____Group# _____ DOB _____

Subscriber's Name:_____ Relation to patient: Self Spouse Parent Other _____

Address (if differs from above):_____City_____State_____Zip _____

Employer _____Occupation _____

Secondary Medical Insurance

Insurance Company _____ Subscriber# _____Group# _____ DOB _____

Subscriber's Name:_____ Relation to patient: Self Spouse Parent Other _____

Address (if differs from above):_____City_____State_____Zip _____

Vision Insurance

Insurance Company _____ Subscriber# _____Group# _____ DOB _____

Subscriber's Name:_____ Relation to patient: Self Spouse Parent Other _____

Address (if differs from above):_____City_____State_____Zip _____

Assignment and Release

Non-Covered Services: Any care not paid for by your existing insurance overage will require payment in full at the time of service or upon notice of insurance claim denial. I understand the charges for refraction or contact lens services may not be a covered benefit of my insurance, and I agree to be responsible for these charges.

Signature on File / Assignment of insurance benefit: I hereby assign all medical or Medicare benefits to which I am entitled, private insurance and any other health plans to Ninh H. Tran, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

I have read, understood and agreed to the above financial policy for payment of professional fee. The patient is ultimately responsible for all professional fees.

Signature _____Date _____