Young Styles Eye Care

4605 Barranca Parkway, Ste 100
Irvine, CA 92604

Dr. Efraim Duzman and Associates Welcome You to Our Office!

Child
Last Name: Mr. / Ms _____ First Name: _____ Initial: ____ Nick name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home/Cell ( ) _____ Birth Date: _____/_____/_____ Age: _____ SS # _____
Month Day Year

Child School Name: _____ City: _____ Grade: _____

Primary Care Physician: _____ City: _____ Phone: ( ) _____

Reason for your child vision care today? _____

Would you like exam for glasses, contacts, both or other? _____

Would you like us to schedule your child next appointment? (Please Circle) YES NO

Emergency contact person: _____ Relationship: _____ Phone: ( ) _____

INSURANCE

Policy Holder Last Name _____ First Name: _____ Relation to Patient: _____

Name of Insurance Co.: _____ Social Security # _____ ID# _____

Policy Holder Employer _____ Occupation: _____

Home ( ) _____ Cell ( ) _____ Work ( ) _____ Ext _____

Secondary Insurance: Last Name _____ First Name: _____ Relation: _____

Name of Insurance Co.: _____ Social Security # _____ ID# _____

REFERRED BY

How did you hear about us? **Doctor Name**: _____ Friend: _____

(Please Circle): Insurance Referral Internet Driving/Walking Other: _____

PAYMENT METHOD Visa MasterCard Discover Debit Checks Cash

Payment is due on the day of service. If your insurance does not cover any services or materials YOU ARE ***RESPONSIBLE FOR THE BALANCE***

Signature of Guardian or Responsible Party: _____ Date: _____