



Dr. Carl V. Nicholson, Inc.
Medical Information

Vision One Optometry
7 W. Foothill Blvd.
Suite 201
Arcadia, CA 91006
(626) 795-3453

Last Name First Name MI

Address City Zip

Telephone (H) Telephone (W) E-mail Address

Social Security No. Date Of Birth Age

Occupation Employer

Emergency Contact Person/ Telephone No.

Do you have insurance? Yes No

What type of insurance do you have?

Medicare Vision Plan
Medi-Cal Other

Date of Last Eye Exam Dilated?

Family History

High blood pressure Diabetes Retinal detachment Glaucoma Cataracts Macular degeneration Other eye condition(s)
yes no Relation
yes no Relation
yes no Relation
yes no Relation
yes no Relation
yes no Relation
yes no What Kind?

Insurance Assignment

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plans to: Dr. Carl Nicholson. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid and original. I understand that I am financially responsible for all charges necessary to secure the payment.

Please Sign