Dennis A. Chuck, M.D., Inc,
1774 Alameda Street, Pomona, Ca. 91768 (909) 622-1188

PATIENT INFORMATION

Date:_____ Email Address_____

Patient Name_____Home Telephone( )_____
Dr. Mr. Mrs . Ms Miss (Circle one)

Home Address_____Date of Birth_____

_____Social Security No. _____-_____-_____

_____Sex: Male ( ) Female ( )

Occupation_____Work Telephone( )_____

Work Address_____

Parent or Spouse's Employer_____ Work Telephone( )_____

Whom may we thank for referring you?_____

Reason for today's visit:_____

WORK INJURY? Yes( ) No( )

INSURANCE INFORMATION

RESPONSIBLE PARTY INFORMATION:

Who is responsible for this account?_____

Relationship to Patient_____

PRIMARY INSURANCE:

Insurance Co._____

Policy or ID No._____

Are you enrolled in a HMO Health Plan? Yes( ) No( )

DO YOU HAVE VISION INSURANCE? Yes( ) No( )

SECONDARY INSURANCE:

Is patient covered by additional insurance? Yes( ) No( )

Subscriber's Name_____

Relationship to Patient_____

Date of Birth_____ Social Security No. _____

Insurance Name_____ Telephone _____

Address_____

EMERGENCY CONTACT

Name_____ Telephone_____

MEDICAL HISTORY

**********PLEASE PRINT**********

Patient Name_____

Date of Last Eye Exam._____**Name of Previous Eye Doctor**_____

Do you or anyone in your immediate family have a history of the following?

	Yourself	Family		Yourself	Family
Diabetes	( )	( )	Blindness	( )	( )
Cataract	( )	( )	High Blood Press.	( )	( )
Thyroid	( )	( )	Turned or Lazy Eye	( )	( )
Glaucoma	( )	( )	Heart Condition	( )	( )
Aids/HIV	( )	( )	Arthritis	( )	( )
Herpes	( )	( )	Hepatitis (Type_____)	( )	( )
Lupus	( )	( )	Tuberculosis	( )	( )
Asthma	( )	( )	Cancer (Type_____)	( )	( )
Other_____	( )	( )			

Please check any of the following conditions that apply to you:

Frequent Headaches ( ) Drug Allergies ( ) Pregnant ( ) Allergies/Sinus Trouble ( )

Have you ever had the following?

Eye Surgery	( )	Sensitivity to Light	( )	Eye Infection	( )
Eye Injury	( )	Eye Disease	( )	Floaters or Spots	( )
Flashes of Light	( )	Double Vision	( )	Eye Strain	( )
Severe Eye Pain	( )	Poor Distance Vision	( )	Poor Near Vision	( )
Eye Burn, itch, or water	( )				

Do you currently wear glasses? Yes( ) No( ) Contact Lenses? Yes( ) No ( )

When do you wear your glasses?

All the time	( )	Work Safety	( )	Reading:Near/Work	( )
Distance/Task Only	( )	Computer Work	( )	Other, please explain_____	

Do you work at a computer or video display terminal? Yes( ) No( )

Past Surgeries:

Type of Surgery	Date

I HEREBY AUTHORIZE MEDICAL OR EXAMINATION TREATMENT BY THE DOCTOR IN PERSON, OR PROVIDER UNDER HIS SUPERVISION.

Signature_____ DATE_____

MEDICATION DOCUMENTATION

In order to be within current guidelines we need the following information completed.

You help in this matter if greatly appreciated.

Medication/Supplemental	Dosage	Frequency

Medication allergies

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____

_____ and assign directly Dennis A. Chuck, M.D., Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party's Signature_____

Relationship_____Date_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to Dennis A. Chuck, M.D., Inc. for any services furnished me by Dr. Chuck. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Beneficiary_____

Date_____

CASH PAYMENTS

I UNDERSTAND THAT PAYMENT IS DUE IN FULL WHEN SERVICES ARE RENDERED.
I AGREE TO PAY: CASH( ) CHECK( ) CREDIT CARD( )

Signature_____Date_____

REFRACTION FINANCIAL AGREEMENT

I, the undersigned, have researched my insurance plan and am aware that my insurance policy does not cover a refraction visit with Dr. Chuck. If I desire a prescription, I will be financially responsible and will pay as a cash patient for this refraction.

Responsible Party's Signature Date

Witness' Signature Date

DENNIS A. CHUCK, M.D., INC.
1774 ALAMEDA STREET, POMONA, CA. 91768
TEL: 909-622-1188 FAX: 909-623-4768

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The purpose of this form is to comply with the Federal Government mandate to protect patient privacy.

With my consent, Dennis A. Chuck, M.D. may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and healthcare Operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent.

Dennis A. Chuck, M.D. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written requests to the office of Dennis A. Chuck, M.D., Inc. at 1774 Alameda Street, Pomona, Ca 91768.

With my consent, Dennis A. Chuck, M.D., Inc. May call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointments, reminders, or insurance items, and any call pertaining to my clinical care, including laboratory results.

With my consent, Dennis A. Chuck, M.D., Inc. may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and correspondences.

Signed_____ Date_____

Vision & Your Lifestyle

Please take a moment to complete this questionnaire so that we can better understand your vision needs.

Name_____ Date of Birth_____

What is your occupations?_____

How many hours do you spend reading each day?_____

How many hours do you spend on a computer each day?_____

CIRCLE ONE:

Do your eyes feel tired or strained at the end of the day?	YES	NO
Do you experience sensitivity to light?	YES	NO
Does glare or reflections bother you?	YES	NO
Does driving/riding in a car at night bother you?	YES	NO
Do you wear sunglasses with UV protection?	YES	NO
Do you wear Rx sunglasses?	YES	NO

YOUR LEISURE ACTIVITIES:

( ) Tennis
( ) Water Sports
( ) Drawing/Painting
( ) Reading
( ) Fishing
( ) Golfing
( ) Other (Specify)_____

Thank you *for completing this form.*