

PATIENT INFORMATION

Patient Name: _____ Email Address: _____
Home Phone: _____ Home Address: _____
Date of Birth: _____ Social Security No.: _____ Sex: Male Female

WORK INFORMATION

Occupation: _____ Work Phone: _____
Work Address: _____ Work Injury? Yes No
Parent or Spouse's Employer: _____

INSURANCE INFORMATION

RESPONSIBLE PARTY INFORMATION:

Who is responsible for this account? _____
Relationship to Patient: _____

PRIMARY INSURANCE

Insurance Company: _____ Policy or ID Number: _____
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 Company: _____ Phone: _____
Insurance Company Address: _____

EMERGENCY CONTACT

Emergency Contact Name: _____ Phone: _____
Relationship: _____



MEDICAL HISTORY

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?

Table with 6 columns: Condition, Yourself, Family, Condition, Yourself, Family. Rows include Diabetes, Cataract, Thyroid, Glaucoma, Aids/HIV, Herpes, Lupus, Asthma, Blindness, High Blood Pressure, Turned or Lazy Eye, Heart Condition, Arthritis, Hepatitis, Tuberculosis, Cancer.

Other: _____

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

- Frequency of Headaches, Drug Allergies, Pregnant, Allergies/Sinus Trouble

Have you ever had the following?

- Eye Surgery, Eye Injury, Flashes of Light, Severe Eye Pain, Eye Burn, Itch, or Water, Sensitivity to Light, Eye Disease, Double Vision, Poor Vision, Eye Infection, Floaters or Spots, Eye Strain, Poor Near Vision

Do you currently wear glasses?..... Yes No Do you currently wear contact lenses?.... Yes No

When do you wear your glasses?

- All the time, Distance/Task Only, Work safety, Computer work, Reading: Near/Work, Other

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



MEDICATION ALLERGIES

1. _____
2. _____
3. _____
4. _____
5. _____

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 authorize 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: _____ Date: _____

Relationship: _____

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 Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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.

Signature: _____ 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