Clear Vision Eye Center

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

Date: _____

PATIENT INFORMATION

Patient Name: _____ Email: _____

Dr., Mr., Mrs., Miss, Ms.

Phone: _____

Home Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Sex: ☐ Male ☐ Female

Reason for Visit: _____ Social Security No.: _____

Who Referred You: _____

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: _____

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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?

	Yourself	Family		Yourself	Family
Diabetes:	☐	☐	Blindness:	☐	☐
Cataract:	☐	☐	High Blood Pressure:	☐	☐
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	☐ Floaters or Spots
☐ Eye Injury:	☐ Eye Disease	☐ Eye Strain
☐ Flashes of Light:	☐ Double Vision	☐ Poor Near Vision
☐ Severe Eye Pain:	☐ Poor Vision	
☐ Eye Burn, Itch, or Water:	☐ Eye Infection	

Do you currently wear glasses?_____ ☐ Yes ☐ No **Do you currently wear contact lenses?**____ ☐ Yes ☐ No

When do you wear your glasses?

☐ All the time	☐ Work safety	☐ Reading: Near/Work
☐ Distance/Task Only	☐ Computer work	☐ Other _____

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

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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: _____

I acknowledge that I may be charged $150 for failure to keep appointment without 24 hour notice of cancellation

Signature: _____ Date: _____

MEDICATION DOCUMENTATION

Please Provide Complete List of Current Medication

Medication/Supplemental	Dosage	Frequency

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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: _____

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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: _____

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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: _____

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Please don't hesitate to ask if you have any questions

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