WELCOME TO THE OFFICES OF DR. LORI KAM AND DR. STEPHEN CHING

Patient Information Sheet

Please complete all applicable information so we may more efficiently serve you.

Patient's name:(Mr.Mrs.Miss)______________________________Sex: M F Todays date:___/___/20__
last name, first name

Patient's date of birth:__/__/____Age: _____ Social social security#:______________________________

Home address:______________________________City:______________________Zip code:__________

Home phone: (___)________________Work phone:(___)______________Msg phone:(___)__________

e-mail address:________________________

Who do we contact in case of emergency?_______________relationship to you_________ph:_________

Complete 1,2,3 if applicable. For minors, give parent information. If married, give spouse information, also.

1) Patient's employer:__________________________Occupation:____________Duration:_______years
   Insurance co.:______________________________ID orSS#_____________________________
2) (Wife-Mother) name:______________________DOB:__/__/____Work phone:(___)________________
   Employer:_________________Insurance co.:________________ID orSS#:___________________
3) (Husband-Father)name:__________________DOB:__/__/____Work phone:(___)________________
   Employer:_________________Insurance co.:________________ID orSS#:___________________

Who may we thank for referring you to our office?____

MEDICAL INFORMATION

When was your last physical exam?___/___/ _______Who is your primary care M.D.?_______________

Are you pregnant or nursing? Y/N

*List all medications you are currently taking (Rx and nonRx):*_____________________________________

____

Medication allergies:__________________________ What was reaction?_________________________

Date of last tetanus shot:__/__/____ Do you use cigarettes/tobacco? Y/N Alcohol? Y/N Other? Y/N

Circle All that apply to you (Me) or blood relative (BR):

Eye injury	Me	High cholesterol	Me/BR	Rheumatoid arthrtitis	Me/BR
Eye surgery	Me	High blood pressure	Me/BR	Epilepsy	Me/BR
Cataracts	Me/BR	Diabetes	Me/BR	Mental disorder	Me/BR
Glaucoma	Me/BR	Cardiovascular disease	Me/BR	Allergies	Me/BR
Lazy eye	Me/BR	Thyroid	Me/BR	Asthma	Me/BR
Respiratory disease	Me/BR	Blood disorder	Me/BR	Headaches	Me

EYE HISTORY

Is this exam for glasses__,contact lenses__,vision therapy__, surgery__,other______________________

Would you like the doctor to discuss vision corrective surgery options? yes___ no___

When was your last eye exam?___/____/_________ Do you wear glasses? Y/N Contact lenses? Y/N

In order to help us provide you with personalized service and eyewear please answer the following:

What are your hobbies?____

Do you work on a computer? Y/N, if yes, approximately how many hours a day?_______

Do you notice 'halos' while driving at night? Y/N, or do you squint outdoors? Y/N

Do your glasses feel heavy, hurt your nose, or slide down your face? Y/N

Are you rough on your glasses? Y/N

Do you wear your glasses when you participate in sports or while at the gym? Y/N

Do you enjoy activities in or around water? Y/N

Do you feel your glasses are an accessory? Y/N

Attending physician's initials:___________

PATIENT CONSENT

Payment terms

Please understand that our offices do their very best to know your insurance policies for reimbursement. We do our best to quote you on the overages. Should your insurance pay less than we expect, you will be responsible for the difference.

A minimum of 1/2 down is required to process your eyewear. Payment in full is required by or at pick-up.

I agree to the above. Signature:________________________________ date:__/__/____

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Drs. Kam or Ching for any services furninshed to me by that physician. I authorize any holder of medical information about me to release to the HCFA and its agents, and any information needed to determine these benefits payable to related services, I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of HCFA1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown in Medicare assigned cases, the physician 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 deductibles are based upon the charge determination of the Medicare carrier.

Signature:_____________________________ date:__/__/____