Simply Eyes HAWAII

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PATIENT INFORMATION

LAST NAME | FIRST NAME | MIDDLE INITIAL

SALUTATION (PLEASE CIRCLE): MR. MRS. MISS MS. DR. OTHER:_____

DATE OF BIRTH

HOME ADDRESS | HOME PHONE

CITY | STATE | ZIP CODE

MAILING ADDRESS

CITY | STATE | ZIP CODE

OCCUPATION | EMPLOYER | WORK PHONE

REFERRED BY

PERSON RESPONSIBLE FOR THE ACCOUNT: ☐ SELF ☐ SPOUSE ☐ PARENT

NAME

ADDRESS

INSURANCE INFORMATION: Please give all insurance cards to the receptionist.

Name of Medical or Vision Insurance Plans: _____

Medicare/Medicaid/Healthquest: _____

Other: _____

I understand that I am responsible for all charges for services provided by Tracie M. Inouchi, O.D., Sherry S. Y. Wong, O.D., & Daniel M. Yamamoto, O.D. I authorize the release of any medical information to process my insurance claims and request payment of insurance benefits to either myself or the party who accepts assignment/participation with my insurance company.

X _____ – –

SIGNATURE (PATIENT, PARENT, OR GUARDIAN) | DATE