

PATIENT INFORMATION

NAME: _____ BIRTHDATE: _____
ADDRESS: _____ CITY _____, HI, ZIP CODE _____
HOME #: _____ WORK/DAY#: _____ CELL#: _____ ☐ Ok to text?
OCCUPATION _____ EMPLOYER _____
EMAIL ADDRESS: _____

Medical Insurance _____ **Vision Insurance** _____
Subscriber's Name _____ **Subscriber's Date of Birth** _____

How were you referred to us: _____

I request that payment of authorized Insurance benefits for any services furnished me, be made on my behalf to **Nora M.Y. Chan, O.D., Inc.** I authorize any holder of medical information about me to release my insurance company any information needed to determine these benefits or the benefits payable for related services. I understand that I am responsible for charges not paid by my insurance plan and I understand the Notice of Privacy Practices (HIPAA-Revised January 2016):

X _____ **Date** _____
Signature of Patient/ Parent/ Legal Guardian

***** **FOR DOCTORS & STAFF USE** *****

<p>Exam Type: <input type="checkbox"/> Vision 92 _____ <input type="checkbox"/> Medical _____ <input type="checkbox"/> Refraction <input type="checkbox"/> Cataract Post Op 66984 Modifiers ___ 55 ___ Rt ___ Lt Contact Lens Fitting: <input type="checkbox"/> Existing wearer <input type="checkbox"/> New Fit <input type="checkbox"/> Medical Fit Bandage Contact Lens Fitting <input type="checkbox"/> 92071 Corneal Topography <input type="checkbox"/> 92025 Epilation <input type="checkbox"/> 67820 _____ Lid(s) FB removal <input type="checkbox"/> Cornea 65222 FB removal <input type="checkbox"/> Conjunctiva embedded 65210 <input type="checkbox"/> superficial 65205 Gonio <input type="checkbox"/> 92020 OCT <input type="checkbox"/> Optic Nerve 92133 <input type="checkbox"/> Retina 92134 Pachymetry <input type="checkbox"/> 76514 Photo <input type="checkbox"/> Anterior 92285 <input type="checkbox"/> Posterior 92250 Visual Fields <input type="checkbox"/> 92083 <input type="checkbox"/> other _____ Other: _____ CHARGES:</p>	<p>___ OM/INSURANCE info updated ___ Screened DFE 1 _____ Appointment: 2 _____ <input type="checkbox"/> Photos _____ Check-in: _____ <input type="checkbox"/> OCT _____ <input type="checkbox"/> FDT _____ Dr. Exam In: _____ <input type="checkbox"/> Fields _____ Out: _____ <input type="checkbox"/> Dispensed CL trials@ B _____</p>
---	--

<p style="text-align: center;"><u>Single Vision</u></p> <p><input type="checkbox"/> Distance <input type="checkbox"/> Readers <input type="checkbox"/> Computer/Intermediate <input type="checkbox"/> Sunglasses <input type="checkbox"/> Safety Glasses <input type="checkbox"/> Optional <input type="checkbox"/> Ocular fatigue (Eyezen/Sync)</p> <p style="text-align: center;"><u>Multifocal</u></p> <p><input type="checkbox"/> ST 28 <input type="checkbox"/> ST 35 <input type="checkbox"/> Trifocal ST ___ X ___ <input type="checkbox"/> Progressive _____ <input type="checkbox"/> Computer _____</p> <p>MONOC PD DIST (OD) _____ / (OS) _____ <input type="checkbox"/> ORDERED <input type="checkbox"/> NOT INTERESTED</p>	<p style="text-align: center;"><u>Material</u></p> <p><input type="checkbox"/> CR 39 <input type="checkbox"/> Trivex/Polycarb <input type="checkbox"/> Mid Index <input type="checkbox"/> High Index</p> <p style="text-align: center;"><u>Photo-chromatic</u></p> <p><input type="checkbox"/> Tint <input type="checkbox"/> Solid <input type="checkbox"/> Gradient <input type="checkbox"/> BluTech <input type="checkbox"/> Transitions <input type="checkbox"/> XTRActive <input type="checkbox"/> Polaroid</p> <p style="text-align: center;"><u>Anti-Glare</u></p> <p><input type="checkbox"/> Sapphire <input type="checkbox"/> Previncia <input type="checkbox"/> Avance <input type="checkbox"/> Other</p>
--	--

<u>Contact Lenses</u>	
<p>ORDER: <input type="checkbox"/> Trials <input type="checkbox"/> Final CLRx <input type="checkbox"/> Call to finalize CLRx CL Solution: <input type="checkbox"/> ORDERED <input type="checkbox"/> NOT INTERESTED <input type="checkbox"/> CL Trials Scanned <input type="checkbox"/> Please Scan Trials</p>	<p><input type="checkbox"/> Referral to Specialist: _____ Diagnosis: _____ Appoint Date/Time: _____ <input type="checkbox"/> Letter to PCP _____ <input type="checkbox"/> Call Rx to Pharm. _____ Recommended product _____</p>
<p><input type="checkbox"/> Next Visit _____ <input type="checkbox"/> Recheck Reason: _____ <input type="checkbox"/> pachymetry <input type="checkbox"/> OCT <input type="checkbox"/> Photos <input type="checkbox"/> Fields <input type="checkbox"/> Gonio <input type="checkbox"/> clck/cld <input type="checkbox"/> IOP <input type="checkbox"/> Dilation <input type="checkbox"/> Complete Eye Exam Sample/Coupon for _____ Assistant _____</p>	