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* **********

Exam Type: □ Vision 92_____ □ Medical _____ □ Refraction
□Cataract Post Op 66984 Modifiers___55 ___Rt____Lt
Contact Lens Fitting: □ Existing wearer □ New Fit □ Medical Fit
Bandage Contact Lens Fitting □ 92071 **Corneal Topography** □ 92025
Epilation □67820 _____Lid(s) **FB removal** □ Cornea 65222
FB removal □Conjunctiva embedded 65210 □ superficial 65205
Gonio □ 92020 **OCT** □ Optic Nerve 92133 □ Retina 92134
Pachymetry□76514 **Photo** □ Anterior 92285 □ Posterior 92250
Visual Fields □ 92083 □ other_____ **Other:**_____
CHARGES:

___**OM/INSURANCE info** updated__Screened
DFE 1 _____ **Appointment:**
2_____
□ **Photos** _____ **Check-in:** _____
□ **OCT** _____
□ **FDT** _____ **Dr. Exam In:** _____
□ **Fields** _____ **Out:**_____
□ **Dispensed CL trials@** B__

Single Vision
□ Distance □ Readers □ Computer/Intermediate
□ Sunglasses □ Safety Glasses □ Optional
□ Ocular fatigue (Eyezen/Sync)

Multifocal
□ ST 28 □ ST 35 □ Trifocal ST___X___
□ Progressive_____ □ Computer_____

MONOC PD DIST (OD)_____/(OS)_____
□ **ORDERED** □ **NOT INTERESTED**

Material
□ CR 39 □Trivex/Polycarb □ Mid Index □ High Index

Photo-chromatic
□ Tint □ Solid □ Gradient □ BluTech
□ Transitions □XTRActive □ Polaroid

Anti-Glare
□Sapphire □ Prevencia □ Avance □ Other

Contact Lenses
ORDER: □Trials □ Final CLRx □ Call to finalize CLRx CL Solution:
□**ORDERED** □ **NOT INTERESTED** □ CL Trials Scanned □ Please Scan Trials

□ Referral to Specialist:_____
Diagnosis:_____
Appoint Date/Time:_____
□ Letter to PCP _____
□ Call Rx to Pharm. _____
Recommended product _____

□ Next Visit_____
□ Recheck Reason:_____
□ pachymetry □ OCT □Photos □ Fields □ Gonio □clck/cld
□ IOP □ Dilation □ Complete Eye Exam
Sample/Coupon for _____
Assistant _____