Date _____

Karen H Chao O.D. Inc.
121 S Del Mar Ave Suite A
San Gabriel, CA 91776
626-287-0401

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____

Birthday ____ / ____ / _____ ❑Male ❑Female Ethnicity: _____ SSN: _____

Marital Status: ❑Single ❑Married ❑Separated ❑Divorced ❑Widowed ❑Domestic Partner

Address _____

City _____ State _____Zip _____

Preferred Telephone # for Routine Communication: _____ ❑Home ❑Work ❑Cell

Secondary Phone: _____ ❑Home ❑Work ❑Cell

Email _____@_____ Receive office communication via TEXT and email? ❑Y ❑N

Primary Spoken Language ❑English ❑Other _____

Primary Care Physician _____ Ofc. Address _____

Occupation _____ Employer's Name _____

Referred By: _____ ❑Family ❑Friend ❑Doctor ❑Insurance ❑Other

EMERGENCY CONTACT

Please provide an emergency contact. If patient is under 18, please list an alternate contact other than the parent/guardian.

Contact Name _____ Relation to Patient _____

Address _____

City _____ State _____Zip _____

Home Phone: (_____) _____ Work Phone (_____) _____ Cell Phone: (_____) _____

RESPONSIBLE PARTY 1

❑ *Same as above. I am the responsible party*

Parent/Guardian Name

_____

❑Mother ❑Father ❑Guardian ❑Other _____

Birthday ____/____/_____ ❑Male ❑Female

❑Single ❑Married ❑Separated

❑Divorced ❑Widowed ❑Other

Address _____

City _____ State _____ Zip _____

**Check the box for preferred method of communication*

❑Home _____ ❑Mail

❑Cell _____ ❑Work _____

❑Email _____@_____

Occupation _____

Employer _____

RESPONSIBLE PARTY 2

Parent/Guardian Name

_____

❑Mother ❑Father ❑Guardian ❑Other _____

Birthday ____/____/_____ ❑Male ❑Female

❑Single ❑Married ❑Separated

❑Divorced ❑Widowed ❑Other

Address _____

City _____ State _____ Zip _____

**Check the box for preferred method of communication*

❑Home _____ ❑Mail

❑Cell _____ ❑Work _____

❑Email _____@_____

Occupation _____

Employer _____

Name _____

Date of Birth _____

Today's Date _____

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INSURANCE SUBSCRIBER INFORMATION

Thank you for providing copies of your insurance card(s). Please fill in the following information:

Vision Insurance ❑VSP ❑EyeMed ❑MES ❑Other _____

Subscriber's Name _____ Birthday ____/____/_____ Relation to patient _____

Subscriber ID _____ Subscriber SSN _____

Primary Medical Insurance Company Name ❑Medicare ❑Other _____

Subscriber's Name _____ Birthday ____/____/_____ Relation to patient _____

Subscriber ID _____ Subscriber SSN _____

Secondary Medical Insurance Company Name ❑Medicare ❑Other _____

Subscriber's Name _____ Birthday ____/____/_____ Relation to patient _____

Subscriber ID _____ Subscriber SSN _____

ELIGIBILITY GUARANTEE

I hereby certify that I am eligible with the health insurance company under the subscriber indicated on my registration sheet. I also certify that I have chosen Karen H Chao, O.D., Inc. DBA San Gabriel Family Optometry to provide vision care services and/or materials. I understand that if the above is not true or I am not eligible under the terms of my Vision Insurance Agreement, I am liable for any and all charges for services rendered and materials purchased. Also, if the above is not true, I agree to pay in full for all services rendered within thirty days of receiving a bill.

Signature _____ Date _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment of benefits be made directly to Karen H Chao, O.D., Inc. DBA San Gabriel Family Optometry for services and/or materials provided to me by San Gabriel Family Optometry and that I am financially responsible for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverage's are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.

Signature _____ Date _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or any public agency and its agents to determine benefits for services provided or benefits for related services.

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICE

HIPAA (Health Insurance Portability and Accountability Act) regulations require us to provide to you, the patient or personal representative, a copy of our Notice of Privacy Practice and for you to sign as acknowledging receipt of this brochure.
http://www.sgfamilyoptometry.com/privacy-notice.html Initials _____

You may share health information about the patient's condition with: _____
Name(s) of family members/friends/significant others.

Signature _____ Date _____