Welcome To Our Office

Joseph K. Kikumoto, O.D.
Ryan K. Onishi, O.D.
Steve M. Dao, O.D & Nina H. Dao, O.D.

Patient Information

Thank you for choosing our practice for your eyecare needs. If you have any questions or concerns, please do not hesitate to ask.

(Please Print)

Circle your title Mr. Mrs. Miss Ms. Dr.

Name _____ Date _____
First MI Last

Address _____ City _____ State ____ Zip _____

Birthdate _____ Age ____ Sex M / F Email _____ Social Security # _____

Home phone # _____ Work phone # _____ Name you prefer to be called _____

You/your parent's employer _____ Occupation _____

Business address _____ City _____ State ____ Zip _____

Spouse or parent's name _____ Workplace _____ Work phone # _____

If student, school/college name _____ City _____ State ____ Grade _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone # _____

EMAIL: _____ (For newsletters and appointment reminders)

Responsible Party

Name of person responsible for account _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State ____ Zip _____

Name of employer _____ Work phone # _____

Insurance Information

Name of Insured _____ Relation to patient _____ Birthdate _____

Social Security # _____ Name of employer _____ Work phone # _____

Address _____ City _____ State ____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. address _____ City _____ State ____ Zip _____

EVEN IF YOUR INSURANCE COMPANY WILL PAY FOR PART OF OUR SERVICES, YOU ARE RESPONSIBLE FOR THE COMPLETE BILL AND THE INSURANCE COMPANY MAY REIMBURSE YOU.

Regarding the payment of your account: When contact lenses or glasses are ordered, half or full payment is requested following the exam. The balance is due when the contact lenses or glasses are dispensed. Any other financial arrangements should be discussed with the office manager.

Patient signature _____

PATIENT HEALTH HISTORY

Personal Eye History

Date of last eye examination _____ Name of eye doctor _____
Do you wear: Glasses Y N Contact lenses Y N If you wear contact lenses, please list type_____

Please list the name and address of the doctor who fit your contact lenses _____

_____

Have you ever had any eye: Injury Y N date _____ Surgery Y N date _____ Loss of vision Y N

Have you ever been told that you have: Glaucoma Y N Macular degeneration Y N Cataracts Y N

If yes, please explain in detail _____

Please list any other eye conditions _____

Personal Medical History

How is your general health? _____

Date of last physical examination _____ Name of primary care doctor _____
Do you have problems with any of the following?

Ear/Nose/Throat	Y	N	Endocrine (glands)	Y	N
Skin	Y	N	Cardiovascular	Y	N
Blood/Lymph	Y	N	Respiratory	Y	N
High blood pressure	Y	N	Diabetes	Y	N

Please list any other health problems _____

Are you presently taking any medications? Y N Birth control pills Y N Hormones Y N

Please list all medications and reason for taking them _____

_____

Allergies (including medication)? Y N If yes, please list _____

Headaches Y N If yes, location? Front Side Top Back Neck

Use cigarettes/tobacco Y N Alcohol Y N Other substance Y N

Family History

High blood pressure	Y	N	Relation _____
Diabetes	Y	N	Relation _____
Cataracts	Y	N	Relation _____
Glaucoma	Y	N	Relation _____
Macular degeneration	Y	N	Relation _____
Retinal detachment	Y	N	Relation _____
Any other eye conditions	Y	N	Please list _____

Receipt of Notice of Privacy Policies & Consent Form

Ryan K. Onishi, O.D.
Joseph K. Kikumoto, O.D.
Steve M Dao, O.D. &Nina H. Dao, O.D.
31401 Rancho Viejo Rd., Suite 103
San Juan Capistrano, CA 92675
(949) 496-0552
(949) 443-3828 Fax

Patient Name: _____

Patient Phone Number: _____ **Patient Work Phone Number:** _____

Patient Address: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* **you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our** *Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our** *Notice of Privacy Practices***. Our** *Notice of Privacy Practices* **will be updated whenever our privacy practices change. You can get an updated copy here at the office** (or from our website)**.**

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices***.**

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our** *Notice of Privacy Practices* **describes how to ask for a restriction.**

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from the office of Ryan K. Onishi, O.D., Joseph K. Kikumoto, O.D., Steve M. Dao O.D. and Nina H. Dao, O.D.

_____ _____

Signature **Date**

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____

Relationship to Patient **Print Name**

Source of Authority: _____