Rick Nakasone, OD

Serving Orange County for over 25 years

Patient's name Dr. Miss Ms. Mrs. Mr. _____
Last *First* *MI* *Suffix*

Address _____ If married, name of spouse
If child, parents' name _____

City _____ State _____ Zip _____

Cell Phone ( ) _____ Work Phone ( ) _____

Home Phone ( ) _____ Email: _____

If you would like your annual reminders by postcard, please check here ☐

Birthdate _____ Occupation _____

Sex: M F Employer _____ Marital Status _____ Referred by _____

INSURANCE INFORMATION

Vision Insurance: ☐ VSP ☐ MES ☐ Other, please specify _____ Member's ID _____

Member _____ Relationship _____
(if different from above) *Last* *First* *(if different from above)*

Member DOB _____ Medical Insurance _____
(if different from above) *(please have medical insurance card ready)*

MEDICAL INFORMATION

Do you have any problems with any of these? (If yes, please check the box)

☐ High Blood Pressure ☐ Headaches ☐ Glaucoma ☐ Dry Eyes

☐ Macular Degeneration ☐ Flashes ☐ Floaters ☐ Cataracts

☐ Diabetes: Type I / Type II / *(circle one)* ☐ Retinal Detachment

☐ Other Health Problems What kind? _____

	Yes	Quit	Never
Alcohol	☐	☐	☐
Tobacco	☐	☐	☐
Drug	☐	☐	☐

Family Doctor _____

Medication _____ Allergies _____

Do you wear contact lenses? ☐ Yes ☐ No Are you interested in contact lenses? ☐ Yes ☐ No

FAMILY HISTORY

☐ Diabetes Relation _____ ☐ Macular Degeneration Relation _____

☐ Glaucoma Relation _____ ☐ Retinal Detachment Relation _____

PATIENT CONSENT

Congress' passage of the HIPAA act requires us to obtain your consent in order for this office to carry out treatment and process your related insurance correspondence. Please review our Notice of Privacy Practice for a description of such possible uses and disclosures. I understand the following:

- My medical records are confidential.
- I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. Requests may be denied if the information is required for Health Care Operations.
- I am allowing my medical information to be released to the insurer(s) listed above in order to justify insurance reimbursement.
- I authorize the insurance reimbursement to be released directly to Rick Nakasone, O.D.
- I may revoke this consent by written request, at any time with Dr. Nakasone. If revoked, it is understood by all parties that all information released, for Health Care Operations or insurance purposes, prior to being notified of such revocation was made with my consent.

I have read the above and foregoing consent for release of information. I do hereby acknowledge that I am familiar with and fully understand the terms and condition of the consent.

Signature _____ **Date** _____

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