Account # ____________

PATIENT INFORMATION : (Please PRINT clearly)

Name ______________________________ Birthdate ____________ Age ______
Last First M.I.

Home Address ______________________ City ____________ State ________ Zip ____________

Sex ☐ M ☐ F ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Minor SS# (Last 4 digits) ____________

E-mail ____________________ Cell Phone ( ) ____________ Home Phone ( ) ____________

Employer ______________________________ Employer Phone ( ) ____________

Employer Address ______________________ City ____________ State ________ Zip ____________

Relative's Name(not living with you) ____________ Relationship ____________ Phone ____________

Referred by: ☐ Yellow page ☐ Website ☐ Friend ____________ ☐ Dr. ____________ ☐ Relative ____________

Optometrist: ______________________________ Primary Doctor: ______________________________
Phone Number Phone Number

RESPONSIBLE PARTY

Name of Person
Responsible for this account ______________________ Relation to Patient ____________ Birthdate ____________

Address ______________________________ Home Phone ( ) ____________

Employer ______________________________ Employer Phone ( ) ____________

Currently a patient in our office? ☐ Yes ☐ No E-mail ____________ Cell Phone ( ) ____________

INSURANCE INFORMATION (For office use only - do not write below)

Primary Insurance ____________ Med. Cov ____________ Vision Cov. ____________ Effective Date ____________

Subscriber ____________ Relationship ____________ Date of Birth ____________

Secondary Insurance ____________ Med. Cov ____________ Vision Cov. ____________ Effective Date ____________

Subscriber ____________ Relationship ____________ Date of Birth ____________

FINANCIAL RESPONSIBILITY AGREEMENT:

I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to **DR. WILLIAM K. WONG JR. / HAWAII VISION CLINIC, INC.** A copy of this can be used as an original for insurance purposes.

I agree to pay my co-payment portions as services are provided. If there is any balance owed, I agree to pay promptly upon receipt of the monthly statement. I am aware of the additional charge for returned checks ($25).

ACKNOWLEDGEMENT OF PRIVACY NOTICE:

I have been provided an opportunity to read and review the **NOTICE OF PRIVACY PRACTICES** required by HIPAA regulation.

MISSED APPOINTMENT POLICY

Failure to give 24 - hour notice of cancellation of an appointment or not showing up for an appointment can result in a charge of $20.00 on your account. This charge is not covered by your insurance company and is your responsibility.

For your convenience, We do have automated reminder phone calls made two days prior to scheduled appointments.

____ ____________________

Patient's Signature / Legal Guardian **Date**