Welcome to Alameda Eye Physicians

David Bui,MD Jennifer Taylor,MD Dorothy Khong,MD Eugene Lowry,MD

Today's date: _____/_____/_____ Primary Care Physician: _____
Month Day Year

How were you referred to our office:

☐ Referring Physician other than primary care Name: _____ Phone #: _____

☐ Self-Referred ☐ Internet ☐ Other: _____

Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Jr. ☐ Sr. ☐ Other _____

Patient's Name (Last) _____ (First) _____ (MI) _____

Home Address: _____
Street Apt City State Zip

Phone: Home: (_____) _____Work :(_____) _____Cell :(_____) _____

Date of Birth: _____/_____/_____ ☐ Male ☐ Female **Social Security #:** _____

Email address: _____ **ID/License #**:_____ **State other than CA** _____

How do you prefer to be contacted? ☐ Phone ☐ Mail ☐ E-Mail

Race (Check One): ☐ American Indian / Alaska Native ☐ Asian ☐ African American ☐ White/Caucasian

☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Decline **Language**: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner ☐ Widowed

Pharmacy Name: _____ Address: _____

Employer Information

Name of Employer: _____ ☐ Retired ☐ Disabled

Employer Address: _____
STREET CITY STATE ZIP

Responsible Party Information If Other Than Patient

Complete only if the patient is not the responsible party

Parent/Guardian's Name: _____
Last First Middle

Address: _____
Street Apt City State Zip

Phone: Home: (_____) _____Work :(_____) _____Cell :(_____) _____

Emergency Contact Person

Emergency Contact Name: _____
Last First Relationship to Patient

Emergency Contact Phone Number: Home: (_____) _____ Cell: (_____) _____

Authorization To Treat A Minor

As the parent/guardian of the above named minor, I hereby give my consent to Alameda Eye Physicians to treat the above named minor for routine care and emergency care (if needed). I also agree to be responsible for any charges for services rendered. This permission is granted and effective from the date signed and may be revoked by written notice sent to Alameda Eye Physicians.

_____ _____
Parent/Guardian Signature Date

PLEASE TURN OVER

Insurance Information

Please complete and give the front desk copies of your insurance card (s)

Do you have a Vision Plan? ☐ Yes ☐ No If yes, name of plan _____

We are only contracted with Vision Service Plan (VSP)

If VSP complete below

Subscriber: ☐ Self ☐ Other Subscriber's name if not self _____

ID Number: _____ Date of birth: _____/_____/_____
MONTH DAY YEAR

Primary Medical Insurance: _____

Insurance ID Number: _____

Subscriber's Name: _____

Relationship to Patient**:** _____ Date Of Birth: _____/_____/_____
MONTH DAY YEAR

Subscriber's Employer: _____

Secondary Medical Insurance: _____

Insurance ID Number: _____

Subscriber's Name: _____

Relationship to Patient**:** _____ Date Of Birth: _____/_____/_____
MONTH DAY YEAR

Subscriber's Employer: _____

READ! Insurance Authorization Or Patient Responsibility READ!

I request that payment, explanation of benefits and/or correspondence of any kind, for any services rendered to me and/or my dependents be made on our behalf to David P. Bui, MD, Jennifer B. Taylor, MD, Dorothy P. Khong, MD or Eugene Lowry, MD. I understand that it is my responsibility to verify with my insurance carrier whether or not my physician is a participating provider and whether or not service rendered is covered. I realize that I am financially responsible for all services rendered to me and/or my dependents regardless of the decision involving reimbursement by my insurance carrier. I also authorize the above doctors, the holders of my and/or dependents medical information to release to any insurance on file or its agent any information needed to determine benefits payable. I understand that if the physician accepts assignment they agree to accept the allowed determination fee set by the insurance carrier, and I, the patient, if minor, parent or guardian am responsible for any deductible, co-insurance, co-payment and/or any non-covered services. Please be advised that we, the physicians, do not set deductible, co-insurance, co-payment amounts or determine what is not covered. This decision to pay or not pay any claims is based on your insurance benefit(s). I am aware that if I have any financial questions they should be asked before being seen. Our office will try to answer any questions you have but please be advised we can never guarantee coverage. I understand that any payment that is returned by a financial institution will incur a bank and service fee charge. **I understand that my signature below means that I have read, understood and agree to the contract above.**

Patient's signature: _____ Print name: _____

If patient is a minor or a legal guardian sign below

Parent/guardian's signature: _____

Notice Of Privacy Practice

Our office is in compliance with the privacy rule of the health insurance portability and accountability act (HIPAA).
We are required to provide you our office notice of privacy practice. Please sign below to acknowledge that you have received the notice.

By my signature below I acknowledge that I have received the notice of privacy practices of Alameda Eye Physicians

Signature: _____ Name: _____ Date: _____