



San Gabriel
Family Optometry

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

Today's Date _____

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____
 Birthday ___/___/___ Male Female Ethnicity: _____ Driver's Lic #: _____
 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 _____@_____ Do we have permission to contact you via email? Y N
 Primary Spoken Language English Other _____
 Primary Care Physician _____ How were you referred? _____
 Occupation _____ Employer's Name _____
 Name of spouse or significant other _____ N/A

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 xxx/xx/____

Primary Medical Insurance Company Name Medicare Other _____

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

Subscriber ID _____ Subscriber SSN xxx/xx/____

Secondary Medical Insurance Company Name Medicare Other _____

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

Subscriber ID _____ Subscriber SSN xxx/xx/____

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.sgfamilioptometry.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 _____