**DR. DEBBIE KIM**
**OPTOMETRIC PHYSICIAN**

Appointment Date_____

**PATIENT INFORMATION**

Name:_____ Birthdate:_____ Sex: M__ F__

If a minor, parent's name:_____ Relationship:_____

Address:_____

Cell Phone:_____ Home Phone:_____

Email Address:_____ Last **FOUR** digits of Social Security Number:_____

Employer:_____ Occupation:_____

Date of Last Exam:_____ Name of Previous Doctor:_____

**Race (please select):**

☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American

☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline

**Ethnicity (please select):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

**MEDICAL INSURANCE**

Primary Insurance:_____ ID#:_____

Secondary Insurance:_____ ID#:_____

***Please Note: Our office does **NOT** submit to secondary insurances.

If your secondary insurance is **NOT** linked to your primary insurance, you will be responsible for submission.***

**MEDICAL INFORMATION:**

**Do You Suffer From The Following?:**

Diabetes: __No __Yes If Yes, How Long _____

When was your Last Diabetic Check?_____ Medications_____

Do you have any problems with any of these systems?

__ Gastrointestinal
__ Ear/Nose/Throat
__ Cardiovascular
__ Respiratory
__ Headaches
__ Nervous System
__ Genitourinary
__ Musculoskeletal
__ Skin
__ Mental
__ Endocrine (Glands)
__ Blood/Lymph
__ Allergic/Immunologic
__ Surgeries (type & when):

_____

_____

**Please Continue on the Back**

**Please Check Yes or No**

Do you smoke? __ Yes __ No If yes, how much?_____
Do you drink alcohol? __ Yes __ No If yes, how much?_____

Do you take medications? ___ Yes __ No If yes, please list name and how often_____

_____

Do you use other substances? __ Yes __No

If yes, please list them _____

**Do you have a family history of any of the following? If Yes, Please check the box(es).**

__ Diabetes __ Glaucoma __ High Blood Pressure
__ Macular Degenerate __ Retinal Detachment __ Cataracts

**Do you have any of the following? If Yes, Please check the box(es).**

__ Dry Eyes __ Wear Glasses __ Eye Injuries

__ Eye Surgeries __ Blurred Vision __ Wear Contacts

Any eye problems at this time? Please explain:_____

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR DR. DEBBIE KIM, O.D

Print Patient Name_____ Date_____

Signature of Patient or Guardian if under 18_____

**ASSIGNMENT AND RELEASE:**

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIM(S).

Sign_____ Date_____

I AUTHORIZE PAYMENT OF MEDICAL BENEFIT FOR RENDERED SERVICE TO BE MADE DIRECTLY TO DR. DEBBIE KIM, O.D.

Sign_____ Date_____

I REQUEST THAT PAYMENT FOR AUTHORIZE MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO DR. KIM FOR ANY SERVICES FURNISHED TO ME BY THE PHYSICIAN OR SUPPLIER. I AUTHORIZE ANY HOLDER OR MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE HEALTH CENTER FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

Sign_____ Date_____

PLEASE SIGN BELOW THAT YOU HAVE REVIEWED ALL INFORMATION ABOVE
AND IT IS CORRECT TO THE BEST OF YOUR KNOWLEDGE.

Sign_____ Date_____