Jay K. Honda, O.D.

Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Patient's Name ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. **Patient ID:**

Last Name | Middle | First Name | Suffix | Preferred | DOB (mm/dd/yy) | SSN

Mailing Address | **Address Line 2** | Primary Phone ☐ Home ☐ Mobile | Day/Work Phone

City | State | Zip | Country | Emergency Contact | Emergency Phone

Email | Person responsible for this account

ft in cm/m

Height ☐ ft in ☐ cm ☐ m

Weight ☐ lbs ☐ kg

Authorized to discuss health info Name

Relationship to patient

Sex ☐ Male ☐ Female **Patient Status** ☐ Single ☐ Married ☐ Other **Student** ☐ Full Time ☐ Part Time **Employed** ☐

Primary Care Physician

Physician 1 ☐ M.D. ☐ P.A. ☐ N.P. ☐ R.N. ☐ O.D. ☐ Is Primary Care Physician

First Name | Middle | Last Name | Suffix | Clinic Name

Clinic Address | City | State | Zip | Phone

Physician 2 ☐ M.D. ☐ P.A. ☐ N.P. ☐ R.N. ☐ O.D. ☐ Is Primary Care Physician

First Name | Middle | Last Name | Suffix | Clinic Name

Clinic Address | City | State | Zip | Phone

Primary Insurance

Insured's Name (First Name, Middle Initial, Last Name)

Insured's Address | Address Line 2

City | State | Zip | Country

Insured's ID No | Group No | Insured's DOB | Sex ☐ M ☐ F

Pt Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance

Insured's Name (First Name, Middle Initial, Last Name)

Insured's Address | Address Line 2

City | State | Zip | Country

Insured's ID No | Group No | Insured's DOB | Sex ☐ M ☐ F

Pt Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

How did you initially find our office?

Please Read: We ask that the patient's portion is paid at the time services are rendered. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. Payment from my insurance is to be paid directly to . I authorize the use and disclosure of my protected health information for the purposes, treatment, payment, and healthcare operations, as described in the Notice of Privacy Practices, which was offered or provided to me. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks and for appointments not canceled or rescheduled without a 24 hour notice. The undersigned will ultimately be responsible for any bill incurred in this office.

Signature of Patient or Legal Guardian _____ Date _____