



**Demographics**

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  
(last name) (first name) (middle name)

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Social Security # \_\_\_\_\_

Driver's License Number \_\_\_\_\_ State Issued \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Preferred Appt Reminders  Phone  Text  Email How did you hear about us? \_\_\_\_\_

Marital Status \_\_\_\_\_ Partner Name \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Primary Language \_\_\_\_\_

Ethnicity  Hispanic/Latino  non-Hispanic/Latino  Decline to Answer

Race  American Indian/Alaskan Native  Asian  Black/African American  White

Native Hawaiian/Pacific Islander  Decline to Answer  Other

Emergency Contact Name and Number \_\_\_\_\_

**Insurance**

**Primary Insurance** \_\_\_\_\_

Policy/ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Subscriber \_\_\_\_\_ Relation  Self  Spouse  Parent

Subscriber's Employer \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_

Policy/ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Subscriber \_\_\_\_\_ Relation  Self  Spouse  Parent

Subscriber's Employer \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_



## Signature on File, Assignment of Benefits, Financial Agreement

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Medicare: I request that payment of authorized Medicare benefits be made on my behalf to Westwood Eye for services rendered to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine benefits payable for services rendered. I understand my signature requests that payment be made and authorizes release of medical information necessary for processing and reimbursement of claims. If another health insurance provider is listed as a Secondary Insurance, my signature likewise authorizes release of the information to the insurer shown.

Other Insurance: I request that payment of authorized benefits be made on my behalf to Westwood Eye for services rendered to me. I authorize any holder of medical information about me to release to my insurance provider any information needed to determine benefits payable for services rendered. I understand my signature requests that payment be made and authorizes release of medical information necessary for the processing and reimbursement of claims.

Patient is responsible for deductible balances, co-insurance, and non-covered amounts. Initial \_\_\_\_\_

Payment(s)/Co-payment(s) are due at the time service is rendered. Initial \_\_\_\_\_

Westwood Eye does not have the power to waive co-payments and deductibles. Initial \_\_\_\_\_

You are responsible for knowing your insurance benefits. Initial \_\_\_\_\_

Westwood Eye does not prescribe glasses or contacts, no prescription will be given. Initial \_\_\_\_\_

Medical forms to be filled by a physician are \$20.00. FMLA packets are \$40.00. Initial \_\_\_\_\_

No show policy: \$35.00 no show fee. At least 24-hour notice is required to reschedule. Initial \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or authorized representative

\_\_\_\_\_  
Date



**HIPAA Privacy Authorization Form**

I authorize Westwood Eye (Wonchon Lin, MD, PLLC) to use and disclose my protected health information (PHI). Uses and disclosure for Treatment Records, Payment Information, and Healthcare Operations may be permitted without prior consent in an emergency.

This authorization for release of information covers the period of healthcare from all past, present, and future periods. This PHI may be used for medical treatment or consultation, billing or claims payment, or other purposes deemed necessary by Westwood Eye.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

If desired, please list the name(s) of the person(s) who has permission to access to your protected health information. Please also list the type of information they have access to, such as entire medical records or specific dates of service.

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_ Information \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_ Information \_\_\_\_\_

**My signature below acknowledges the receipt of Westwood Eye’s privacy policies. I understand that my permission for the release of my protected health information to parties listed above will remain in effect indefinitely unless revoked in writing.**

Printed name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient (i.e. patient is a minor) \_\_\_\_\_



## Medical History

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Reason for Visit \_\_\_\_\_

Primary Care Provider \_\_\_\_\_ Phone \_\_\_\_\_

Referring Provider \_\_\_\_\_ Phone \_\_\_\_\_

Pharmacy \_\_\_\_\_ Cross Streets \_\_\_\_\_

**Do you have, or have you had in the past, any of the conditions listed below?**

	Yes	No		Yes	No
Autoimmune Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Neuro Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Issues	<input type="checkbox"/>	<input type="checkbox"/>
GI Issues	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

Please specify or include any other conditions not listed above:

**Please list all of the medications you are taking:**

**Please list all of your medication-related allergies:**

**Please list any surgeries you have had:**

**Please list any history of eye issues that you or your family have:**

**Smoking Status:**

- Are you a current tobacco smoker?  Yes  No
- Are you a former smoker?  Yes  No

If yes, start date: \_\_\_\_\_ end date: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient (i.e. patient is a minor) \_\_\_\_\_