PATIENT INFORMATION SHEET
Iris Y. Kuwabara, O.D.

Who referred you here today?____

Patient Last Name:___________________________ First Name____________________ M.I.____

Mailing Address:____

___________________________________ Soc.Sec. #____________________________

Birthdate:______/______/_______ Birth State_____ Mother's Maiden Name_________________

Home Phone:_______________________________ Sex:______ Marital Status:__________

Work Phone:_______________________________ Employer:_________________________________

Cellular Phone:_____________________________ Occupation:_______________________________

Email Address______________________________ Preferred method of contact: phone email usmail

Party Responsible for bill:___________________________ Student?_______Fulltime?_______ Part time?_____

WHO IS YOUR MAIN CONTACT PERSON?

Name:_________________________________

Relation:_______________________________

Spouse's Employer:______________________

Spouse's Work Number:__________________

OTHER CONTACT PERSONS

Name:___________________________________

Relation:_________________________________

Phone #__________________________________

YOUR INSURANCE INFORMATION

Primary Insurance:________________________

Membership #____________________________

Plan/Program Name:_______________________

Subscriber:_______________________________

Employer:________________________________

Relation:_______________ Birthdate:__________

Secondary Insurance:_________________________

Membership #:______________________________

Plan/Program Name:__________________________

Subscriber:__________________________________

Employer:___________________________________

Relation:_________________Birthdate:___________

I hereby authorize Iris Y. Kuwabara, O.D. to release all medical information regarding my illness, care and/or injury to my insurance carriers, any health care facility, and any other physician that would benefit my healthcare.

I understand I am financially responsible to Iris Y. Kuwabara, O.D. for all charges, whether or not they are paid by said insurance. A photocopy of this assignment is valid as the original.

Date:____________________ Signature____
(parent or guardian if patient is a minor)