Richard H. Miyasaka, O.D., LLC PATIENT SIGN IN SHEET DATE_____

Demographics

Last Name _____ ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Prof.
First Name _____ Preferred Name _____
Middle Initial _____ Marital Status ☐ Married ☐ Single ☐ Other
Gender ☐ Male ☐ Female ☐ Unknown Employment Status _____
Date of Birth _____ Occupation _____
SSN _____ Preferred Language _____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to specify

Race ☐ American Indian or Alaska Native ☐ Asian ☐ White or Caucasian
☐ Native Hawaiian or Pacific Islander ☐ Black or African American ☐ Declined to specify

Address & Phone

Street _____ Preferred
City _____ ☐ Cell _____
State _____ Zip _____ ☐ Home _____
Email _____ ☐ Work _____
Preferred Method of Communication ☐ Email ☐ Text ☐ Phone

Referred by _____ May we send a Thank You for the referral? ☐ Yes / ☐ No

Responsible Party ☐ Self / ☐ Other: Name _____ Date of Birth _____
Address _____ Phone _____

Emergency Contact Name _____ Relationship _____ Phone _____

Primary Care Physician's Name _____ Phone _____ Fax _____
Other Doctor's Name (if any) _____ Phone _____ Fax _____

Insurance information (Medical & Vision) – Please provide a copy of your insurance card(s) to the front desk at check-in

Primary Medical Insurance _____ Insured ID _____
Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other
Subscriber's Name _____ Subscriber's Sex ☐ Male ☐ Female ☐ Unknown
Subscriber's DOB _____ Subscriber's last 4 of SSN _____

Secondary Medical Insurance _____ Insured ID _____
Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other
Subscriber's Name _____ Subscriber's Sex ☐ Male ☐ Female ☐ Unknown
Subscriber's DOB _____ Subscriber's last 4 of SSN _____

Primary Vision Insurance _____ Insured ID _____
Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other
Subscriber's Name _____ Subscriber's Sex ☐ Male ☐ Female ☐ Unknown
Subscriber's DOB _____ Subscriber's last 4 of SSN _____

Secondary Vision Insurance _____ Insured ID _____
Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other
Subscriber's Name _____ Subscriber's Sex ☐ Male ☐ Female ☐ Unknown
Subscriber's DOB _____ Subscriber's last 4 of SSN _____

Richard H. Miyasaka, O.D., LLC PATIENT SIGN IN SHEET DATE_____

Other Insurance_____ Insured ID _____
Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other
Subscriber's Name_____ Subscriber's Sex ☐ Male ☐ Female ☐ Unknown
Subscriber's DOB_____ Subscriber's last 4 of SSN _____

Other Insurance_____ Insured ID _____
Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other
Subscriber's Name_____ Subscriber's Sex ☐ Male ☐ Female ☐ Unknown
Subscriber's DOB_____ Subscriber's last 4 of SSN _____

I hereby authorize the providers at Richard H. Miyasaka, O.D., LLC or their representative(s) 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 health care. I assign my insurance benefits including Medicare, HMSA, and/or any other medical and/or vision insurance plan payable to Richard H. Miyasaka, O.D., LLC. The assignment will remain in effect unless revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by my insurance.

Patient or Legal Guardian Signature_____ Date _____

Print name_____ Relationship: ☐ Self / ☐ Other: _____

ACKNOWLEDGEMENT IN RECEIPT OF NOTICE OF USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
from Richard H. Miyasaka, O.D., LLC.

I hereby acknowledge that I have received and reviewed a copy of the Notice of Uses and Disclosure of Protected Health Information from Richard H. Miyasaka, O.D., LLC, that details their Privacy Policy as required by the Health Information Portability and Accountability Act of 1996 ("HIPAA")

Patient or Legal Guardian Signature_____ Date _____

Print name_____ Relationship: ☐ Self / ☐ Other: _____