Anne K. Matsushima, O.D., Inc.
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Honolulu, Hawaii 96816
(808) 734-8870

PATIENT INFORMATION

Date: account #

Patient Name: (last, first, middle)		Sex: M F	Date of Birth: (MM/DD/CCYY)
Home Address: City, State, Zip:	Preferred Contact	Phone numbers	
	☐	Home:	
	☐	Work:	
	☐	Cell:	
Mailing Address:		Email Address:	
SOCIAL SECURITY #:		Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	

Primary Language: ☐ English ☐ Other: _____	Race: (select one) ☐ Asian ☐ Black or African American ☐ White ☐ American Indian or Alaska native ☐ Other	Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Family Physician:		
Employed by:	Occupation:	
Spouse's Name:	Employer:	Work Phone #:
In Case of Emergency, contact:	Relationship:	Phone #:
Referred by:	May we send this person a thank you for your referral? YES / NO	

Medical Insurance	Vision Insurance
Name of primary insurance company:	Name of primary insurance company:
Subscriber Name and Date of Birth:	Subscriber Name and Date of Birth:
Secondary insurance coverage:	Secondary insurance coverage:
Subscriber Name and Date of Birth:	Subscriber Name and Date of Birth:

Person responsible for bill: (and mailing address, if different from above mailing address)
Payment Method: Cash Check Credit Card

- I understand that this office is a participating office with Medicare, HMSA 65C+, HMSA ***Special Vision Plans***, HMAA, HMA Inc., VSP, University Health Alliance, and Tricare, and that I am responsible for the deductible amounts and all extra fees which are not covered by said insurance companies.
- I agree that I am ultimately responsible for the balance on my account for any medical cost and professional services rendered.
- A monthly finance charge of 1.5%(18% APR) will be assessed on remaining balances.
- In the event that a delinquent account is placed in the hands of an attorney or a licensed collector, I agree to pay, in addition to the amount owed, an amount equal to twenty five percent (25%) of the balance thereof to cover all costs of collection, including an attorney's fee.
- I have read all the above information and have answered the above questions. I certify that this information is true and correct to the best of my knowledge.

_____
Signature of patient, parent or guardian