ANNE K. MATSUSHIMA, O.D., INC. 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 ☐ Black or African American
☐ 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 _____

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 Anne K. Matsushima, O.D., Inc. or their representative(s) to release to my insurance company or representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical care. I assign my insurance benefits including Medicare, HMSA, and/or any other medical and/or vision insurance plan payable to Anne K. Matsushima, O.D, Inc. 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 Anne K. Matsushima, O.D., Inc.

I hereby acknowledge that I have received and reviewed a copy of the Notice of Uses and Disclosure of Protected Health Information from Anne K. Matsushima, O.D., Inc., that details their Privacy Policy as required by the Health Information Portability and Accountability Act of 1996 ("HIPPA")

Patient or Legal Guardian Signature _____ Date _____

Print name _____ Relationship: ☐ Self / ☐ Other: _____