Lisa Kay Mao, M.D.
Diplomat, American Board of Ophthalmology

PATIENT INFORMATION

PLEASE PRINT AND FILL OUT COMPLETELY

Date _____ Mr. Mrs. Ms. Rev. Dr. of: _____ Date of Birth: _____

First _____ M.I. ____ Last _____ Spouse: _____

Street Address _____ City _____ State _____ Zip_____

Is this a Nursing Home/Assisted Living Facility? ☐ Yes ☐ No

Social Security #: _____ Email:_____

Phone: Land Line_____ Cell Phone _____ Work _____

Reason for my visit: _____

Out of Area Address: From_____ to _____

Street _____ City _____ State _____ Zip_____

Please check one: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline

Please check one: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Decline

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

INSURANCE

Primary Insurance Co _____ Policy Holder: _____

Primary Holder ID# _____ Policy Holder Date of Birth: _____

Secondary Insurance Co _____ Policy Holder: _____

Primary Holder's ID# _____ Policy Holder Date of Birth: _____

DOCTORS

Name of Primary Care Physician: _____ Phone: _____

Name of Eye Doctor: _____ Phone: _____

REFERRAL INFORMATION

How were you referred to this office? (please check all that apply)

☐ Your Eye Doctor ☐ Your Primary Care Physician ☐ Caridad Clinic/Community Health ☐ Friend

☐ Other _____

PHARMACY

Address _____ Phone: _____

PATIENT NAME (Please print) First _____ M.I. _____ Last _____

PATIENT FINANCIAL AUTHORIZATION

Insurance Lifetime Authorization: I request that payment of my insurance benefits be made to the physicians of Aker Kasten Eye Center. I authorize medical information be released to the insurance company to determine these benefits for services. Fee Consent: I assume full responsibility for all charges at Aker Kasten Eye Center.

Acknowledgement of Self-pay: I understand that if at any time my insurance does not cover my services, I agree to pay all charges.

Patient Signature: X _____ Witness: _____ Date: _____

PLEASE HAVE YOUR INSURANCE CARD and PICTURE ID READY FOR US TO MAKE A COPY

REFRACTION

If you are a new patient and have not been referred by your optometric physician, a baseline refraction will likely be performed on your first visit if you are not seeing 20/20 with your present correction. You may or may not be given a prescription for new glasses based on the results of your refraction. If you are an established patient and your vision has decreased since your last refraction, a new refraction is recommended. **There will be a $75 charge for the refraction, even if you have Medicare, since refractions are not covered by Medicare**.

I understand that a refraction is a non-covered service and payment is expected from me at the time of service.

Patient Signature: X _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the information provided. In accordance with my rights under, and subject to certain restrictions imposed by HIPAA, I may inspect my PHI in the designated record set maintained by Dr. Mao for as long as the PHI is maintained in the designated record set.

X _____ _____

Patient Signature/Authorized Representative Relationship to patient if signed by someone other than patient

Witness: _____ Date: _____

SHARED INFORMATION AUTHORIZATION

☐ I do NOT wish to share my information with anyone at this time.
☐ I DO authorize the sharing of the following information with those listed below:

☐ All Information ☐ Appointment/Demographic ☐ Medical information ☐ Billing Information

Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

This authorization will remain in effect unless terminated by me in writing.

Patient Signature: X_____ Date: _____

NO SHOW POLICY

If you are unable to keep your appointment, please give us the courtesy of a 48-hour minimum advance notice. When an appointment is scheduled, it means that spot is no longer available for anyone else. Because we are very busy, especially during the winter season, many patients have to wait a month or more for an appointment. We would greatly appreciate being able to see them sooner if you're unable to make your appointment. There will be a **$40 charge** if we do not receive at least 48 hour advance notice that you will not be showing up for your appointment.

I have read and understand the No Show Policy above. X _____ Date: _____

Lisa Kay Mao, M.D.

MEDICAL HISTORY

Patient Name: _____ Date: _____

Medical History

Yes No

- ☐ ☐ Hypertension # of years _____
- ☐ ☐ Liver
- ☐ ☐ Cardiac Disease / Chest Pain
- ☐ ☐ Cholesterol
- ☐ ☐ Thyroid Disease
- ☐ ☐ Stroke / TIA
- ☐ ☐ Latex Allergy
- ☐ ☐ Cancer type: _____

Yes No

- ☐ ☐ Pulmonary Disease
- ☐ ☐ Kidney
- ☐ ☐ Diabetes
  Last blood sugar _____ # of years _____
- ☐ ☐ Arthritis
- ☐ ☐ Infectious Diseases
  ☐ Hepatitis ☐ HIV ☐ TB ☐ MRSA
- ☐ ☐ Other: _____

Medications you are currently taking:

Medication	Dose	Frequency

Medication	Dose	Frequency

Medication	Dose	Frequency

Drug Allergies and Reactions: **HAVE YOU EVER TAKEN FLOMAX, AVODART OR JAYLN?** ☐ Yes ☐ No

_____ _____ _____

_____ _____ _____

Your Eye History: (Have you been diagnosed with any of the following conditions in the past?)

Yes No

- ☐ ☐ Cataracts _____
- ☐ ☐ Retinal Disease _____
- ☐ ☐ Glaucoma _____

Yes No

- ☐ ☐ Eye Injury _____
- ☐ ☐ Any Other Eye Disorders: _____

☐ **Cataract Surgery date** Right _____ Left _____

☐ **Yag Laser date** Right _____ Left _____

☐ **Retinal Surgery date** Right _____ Left _____

☐ **LASIK Surgery date** Right _____ Left _____

Surgical History and Hospitalizations within the last year:

Type of surgery / reason for admission	Surgery/admission date	Type of surgery / reason for admission	Surgery/admission date

Family History **(Mother, Father, Grandparent, Sibling)**

Has any member of your family had these diseases (circle all that apply)? ☐ Yes ☐ No ☐ Unknown

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease:

Social History

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

Do you smoke? ☐ Yes ☐ No If yes, how much? _____ How many years? _____

Fax #: 561-338-7785

CONTACT LENS FEES

Information for all Contact Lens Patients

New Patient fitting for contact lens fee is **$275,** which includes two follow-up visits to check your contact lens prescription and fit. *Please note this fee does not include medical eye exams, purchase of contacts, or glasses prescriptions.*

Annual contact lens check fee is **$150** to ensure contact lens is fitting properly and to make adjustments in lens power if needed.

*Please be aware that **not everyone can be fitted successfully with contact lenses**. The above charges will still apply.

I have read and I understand the above policy regarding contact lens fees:

_____ _____

Patient Signature Date