Kenneth Fukuda, O.D.
6270 Irvine Blvd.
Irvine, CA 92620
Phone: (949) 786-0143 Fax: (949) 786-0492
Website: www.WoodburyOptometry.com
E-mail: EyeDrKen@gmail.com

Welcome to Our Office

So that we can help you best, please fill out both sides legibly and completely. Thank You!

Mr./Mrs./Ms./Miss/Dr. Last Name_____ First Name _____ Today's date_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Legally Separated ❑ Widowed

Name you go by (if different) _____ Approximate date of last eye exam _____

Home address _____ Date of birth _____ Sex: M F

City _____ State _____ Zip_____ Social Security number_____

Home phone (_____)_____ Employer (or School) _____

Work phone (_____)_____ Occupation (or Grade) _____

Cell phone (_____)_____ Emergency contact name _____

E-mail address _____ Emergency contact phone (_____)_____

Medical Insurance_____ How will you settle your account today?

Do you participate in a flexible spending account? Y N ❑ Debit Card ❑ Cash ❑ Credit Card

Are you a member of an eye care plan? Y N (if yes, circle your plan below and sign to authorize benefits)

Vision Service Plan (VSP) Medical Eye Services (MES) EyeMed Other _____

If patient is not the member, please provide the following member information: Name _____

Date of birth _____ Social Security number _____

I authorize the payment of any eye care benefits indicated above to my Doctor of Optometry. I understand that I may have co-payments and overages (costs not paid for by the eye care plan), and I am ultimately responsible for all fees incurred.

Patient or Responsible Party's Signature: _____ Date _____

Personal Medical History

Allergies	Y	N	Eye Disease	Y	N
Asthma	Y	N	Eye Surgery	Y	N
Arthritis	Y	N	Eye Injury	Y	N
Cancer	Y	N	Heart Disease	Y	N
Diabetes	Y	N	High Blood Pressure	Y	N

Substance Use

Do you use: ❑ Alcohol ❑ Cigarettes/Tobacco

❑ Other, please list: _____

Do you take any prescription or non-prescription medications regularly? Y N (If yes, please list)

_____

_____

_____

_____

FEMALES: Are you currently pregnant or breastfeeding Y N

Are you allergic to any medicines? Y N (If yes, please list)

How did you first hear about our office?

❑ Family, friend, or co-worker. Who? _____

❑ Doctor Referral. Who? _____

❑ Eye care plan directory.

❑ Yellow pages. Which directory? _____

❑ Internet. Which website? _____

❑ Other. Please specify. _____

Family Medical History

Blindness or Visual Disability	Y	N	Unsure
Cataracts	Y	N	Unsure
Diabetes	Y	N	Unsure
Glaucoma	Y	N	Unsure
High Blood Pressure	Y	N	Unsure
Macular Degeneration	Y	N	Unsure

Other Disease (please specify)

_____

Please complete the back of this page……..

Eye Care for Your Lifestyle			
Do you desire glasses that are thinner, lighter, and more comfortable?	Y	N	
Do you spend much time outdoors?	Y	N	
Do you spend much time working on a computer?	Y	N	
Are your eyes very sensitive to bright lights?	Y	N	
Are you bothered by glare and reflections, especially at night?	Y	N	
Are you interested in wearing the most advanced contact lenses?	Y	N	
Would you like to change your eye color?	Y	N	
Are there times you would rather not wear glasses or contact lenses?	Y	N	
Do you suffer from dry eyes?	Y	N	
If you wear prescription glasses, do you have only one pair?	Y	N	N/A
If you wear bifocal glasses, does the line bother you?	Y	N	N/A
If you wear bifocal or progressive glasses, do you ever wish you could wear contacts?	Y	N	N/A
Are you planning on getting new glasses today?	Y	N	Only if there is a change.

So that we can get to know you better . . . What hobbies, sports, or other activities do you enjoy?

_____

_____

_____

_____

_____

_____

Patient Consent Use and Disclose Health Information

In the course of providing service to you, we create, receive, and store health information that identifies you. Under the Health Insurance Portability and Accessibility Act (HIPAA), our office can use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

I consent to the use and disclosure of my health information for the purpose of treatment, payment, or healthcare operations. It may also become necessary to disclose my protected health information to another entity, and I consent to such disclosures for these permitted uses, including disclosures via fax.

I acknowledge being offered a copy of Woodbury Family Optometry's privacy policy. The choice of taking one with me or not is entirely mine.

Authorization statement: I accept responsibility for payment of any portion of vision services rendered, which are not covered by my vision insurance. PERMISSION IS GRANTED FOR THE RELEASE OF ALL MEDICAL INSURANCE INFORMATION.

Patient name _____ Today's Date _____

Signature of patient (or parent/guardian for minors) _____

Thank You!