PATIENT INFORMATION FORM

Welcome and thank you for choosing our office! In order to serve you properly, please complete this form and return to the receptionist. All information provided is private and confidential.

❑ Mr. ❑ Mrs. ❑ Ms. Todays Date

Social Security: – – Birthday / / Age

Home Phone ( ) Work Phone ( )

Cell Phone ( ) E – Mail

Address Apt#

City State Zip

Sex: ❑ M ❑ F Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Whom may we thank for referring you:

Medical Doctor / PCP:

Occupation: Employer:

Address City State Zip

Person responsible for this account: Relationship:

Address City State Zip

Home Phone ( ) Cell Phone ( )

Driver's License # Employer:

Please list your primary insurance carrier first. Please specify the subscriber on the policy if other than the patient.

Insurance: Policy#

Primary Member: **Primary Member SS#:**

Insurance: Policy#

Primary Member: **Primary Member SS#:**

Emergency Contact: Relationship:

Address City State Zip

Home Phone ( ) Cell Phone ( )

I hereby authorize Dr. Yokoyama to release health care and treatment information necessary to process all claims and I hereby irrevocably assign to Dr. Yokoyama all payments for medical services rendered.

I understand that I am financially responsible for any charges, whether or not covered by insurance.

Signature of responsible party Date

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CHERYL M. YOKOYAMA, M.D., P.S.
EYE SURGEON AND PHYSICIAN
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