Dr. Vernon I. Shibata
1314 S. King Street, Ste. 610
Honolulu HI 96814-1941
Tel: 808-591-5991
Fax: 808-591-8267

WELCOME !

Date Completed: _______________

Date Revised: __________________

*We recently added a few questions for insurance purposes,
please **read through carefully**.

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*:							☐ M ☐ F	**DOB:**
Marital Status:	Single	Partnered	Married	Separated	Divorced	Widowed		**SS#:** - -
Employment:	Student	FT	PT	Self	Unemployed	Retired	Occupation:	

Demographics:	Email:		Home Phone:		
Address:			Work:		
City:	State:	Zip:	Cell:	Text okay?	☐Yes ☐No

Preferred Method of Communication:	Email	Postal	Telephone	**Preferred Language:**	English	Spanish

Ethnicity:	Hispanic or Latino	Native Hawaiian or Other Pacific Islander	Not Hispanic or Latino

Race:	American Indian or Alaska Native	Hawaiian or Other Pacific Islander	Asian	White	Black or African American

Please complete if the person responsible for Billing is other than you:				
Name:				
Address:		City:	State:	Zip:
Phone:		**Relationship:**		

Insurance Information:	**Please present your insurance card to the receptionist when you turn in this questionnaire.**		
Primary:	Subscriber Name:	DOB	Relation
	Subscriber ID#:		
Secondary:	Subscriber Name:	DOB	Relation
	Subscriber ID#:		

CONSENT FOR TREATMENT: I hereby authorize Dr. Vernon I. Shibata to administer any treatment or procedures as may be deemed necessary or advisable for the care of my (my child's) eyes and/or vision. **Initial**_________

RELEASE OF INFORMATION: Dr. Vernon I. Shibata is hereby authorized to furnish from my records, requested information or excerpts to any insurer of the patient for the purpose of remuneration f professional services provided the insured. Dr. Shibata is also authorized to relay pertinent information to hospitals or physicians involved in my present and future care unless otherwise instructed by me in writing. **Initial**________

FINANCIAL AGREEMENT: I agree that in consideration of these services to be rendered by Dr. Shibata, that I obligate myself to pay for any professional fees and/or costs in accordance with the regular rates and terms of Dr. Shibata's office. I understand that I am primarily responsible for the payment of these charges and will thereafter settle my account with the appropriate insurance company or party of my own. Should my account be referred to any attorney for collection, I agree to pay any and all reasonable attorney's fees and collection expenses whether or not a lawsuit is filed. Additionally, I agree to pay interest at the rate of 1.5% per month on any amount due for more than 30 days. **Initial**_________

Please continue to the other side of this form→→→→→