Name:
Chart: Billing ID#:
Date:

PATIENT INFORMATION

KENNETH C. LOW, M.D.
A PROFESSIONAL CORPORATION
STEVEN C. ANDERSEN, M.D.
EYE PHYSICIANS AND SURGEONS
38707 Stivers St., Ste. B, Fremont, CA 94536

PLEASE PRINT

Date of Birth ______ Age ______

NAME OF PATIENT ☐ MR. ☐ MRS. ☐ MISS ☐ MS. ______ (First, Middle, Last)

Driver's License # ______

☐ MALE ☐ FEMALE

Social Security # ______

Home Address ______ (City, State, Zip) Phone ______

Status ☑: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow/Widower ☐ Minor

Employed by ______ Phone ______

Work Address ______ (City) Occupation ______

Spouse or Parent ______ (First, Middle, Last) Date of Birth ______

Employed by ______ Occupation ______

Work Address ______ (City) Phone ______

Name of person to notify in an emergency ______ Relationship to Patient ______

Address ______ (City, State, Zip) Phone ______

Medical Physician ______ (Name, Address) Phone ______

Optometrist ______ (Name, Address) Phone ______

Whom may we thank for referring you? ______

Reason for visit? ______

RESPONSIBLE PARTY FOR PAYMENT

☐ SELF

☐ NAME ______ (First, Middle, Last) Social Security # ______

Home Address ______ (City, State, Zip) Phone ______

Employed by ______ Date of Birth ______

Work Address ______ (City) Phone ______

INSURANCE (please present cards)	**ID #**	**Group #**
☐ Private		
☐ Medicare		
☐ Other ______		

I understand that I will be responsible for payment for any services provided which are not covered by my insurance company or **if proper authorization has not been obtained at the time of service.**

Date ______ Signature of Patient ______

(Please turn over)

FC2

Name:

Chart: Billing ID#:

Date:

PLEASE PRINT

MEDICATIONS: ______________________________

____

____

____

____

____

____

____

ALLERGIES:

- ☐ Penicillin
- ☐ Sulfa
- ☐ Novocain or other anesthetics
- ☐ Codeine
- ☐ Other ______________________

____

____

____

SERIOUS ILLNESSES:

_____ Heart Attack
_____ Angina
_____ Thyroid Disorder
_____ Bleeding Disorder
_____ Diabetes
_____ Lung Diseases (asthma, emphysema, etc.)

_____ High Blood Pressure
_____ Kidney Disorder
_____ Nerve Disease
_____ Stroke
_____ Cancer
_____ Other

EYE HISTORY:

_____ Cataracts
_____ Previous Eye Surgery
_____ Glaucoma
_____ Iris (Inflammation)
_____ LASIK

DOES FAMILY MEMBER HAVE:

Diabetes ______________________

Glaucoma ______________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

KENNETH C. LOW, M.D.
STEVEN C. ANDERSEN, M.D.

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Pr

Signed ______________________________ *Date* ______________________

Print Name ______________________________ *Telephone* ______________________

If not signed by patient, please indicate relationship:

- ☐ Parent or guardian
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient ______________________________________