

Luis C. Omphroy, M.D., L.L.C.  
Ophthalmology  
Physician Office Building  
98-1079 Moanalua Road, Suite 680  
Aiea, HI 96701

Account # \_\_\_\_\_

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (H) \_\_\_\_\_  
Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

SEX: Male / Female  
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_  
Ethnic Origin: \_\_\_\_\_

Marital Status: Single / Married / Widowed  
Divorced / Separated

Employed: Yes / No  
Employed By: \_\_\_\_\_  
Employer Phone No.: \_\_\_\_\_

Student: Yes / No Full-time / Part-time

Referred By: \_\_\_\_\_

Emergency Contact Person:

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone No.: \_\_\_\_\_

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE EITHER TO OR ON MY BEHALF FOR ANY SERVICES FURNISHED BY LUIS C. OMPHROY, M. D., INCLUDING PHYSICIANS SERVICES.

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE ADMINISTRATION AND ITS AGENT ANY INFORMATION NEEDED TO DETERMINE THE BENEFITS FOR RELATED SERVICES.

**RESPONSIBLE PARTY**

(NOTE: IF DIFFERENT FROM PATIENT INFORMATION)

Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (Work) \_\_\_\_\_  
Employer: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Ins.: \_\_\_\_\_  
Ins. No. \_\_\_\_\_  
Subscriber: \_\_\_\_\_  
Sex: Male / Female  
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Secondary Ins.: \_\_\_\_\_  
Ins. No. \_\_\_\_\_  
Subscriber: \_\_\_\_\_  
Sex: Male / Female  
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_  
Patient Signature or Legal Guardian

\_\_\_\_\_  
Date