Lisa Kay Mao, M.D.

PATIENT INFORMATION

PLEASE PRINT AND FILL OUT COMPLETELY

Date ________________ **Mr. Mrs. Ms. Rev. Dr. of:** _________________ **Date of Birth:**________________

First ___________________ **M.I.** ____ **Last** __________________________ **Spouse:** ________________

Local Street Address ____ **Apt #** __________________

City ____ **State** _____________ **Zip** _____________

Name of Development__________________________________ **Is this a Nursing Home?** ☐ **Yes** ☐ **No**

Patient's Email Address: _____________________________ **In Florida from:** ____________ **to** __________

Phone H (   ) _______ - __________ **Cell (   )** ______ - __________ **Work (   )** _______ - __________

Contact person for messages (family or friend)

Name: ____ *Phone: (   )* _______- ___________

Out of Area Address:

Street____ City__________________ State ______ Zip __________

PHARMACY ________________________ ADDRESS___________________________ PHONE ______________

How were you referred to this office (please check all that apply)?

- ☐ Your eye doctor
- ☐ Your Primary care doctor
- ☐ Friend/Reputation
- ☐ Screening Van
- ☐ Radio Advertisement
- ☐ Magazine Advertisement
- ☐ Internet/Website
- ☐ Caridad Clinic
- ☐ Other _________________________

Primary Care Physician: ___________________________________ **Phone: (   )** _________ - ___________

Name of Eye Doctor: ____________________________________ **Phone: (   )** _________ - ___________

Patient's Rights of Disclosures: In general, the HIPAA privacy rule gives the individuals the right to request restriction on uses and disclosures of health information. The individual is also provided the right to request confidential communications of health information be made by alternative means.

List all persons in your household who, in your absence, may make requests on your behalf, and with whom we may speak regarding your medical records.

____ ____

____ ____

Fax #: 561-338-7785