



HAWAII VISION

SPECIALISTS

OPHTHALMOLOGY & OPTOMETRY

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hawaiivisionspecialists.com

Patient Information

Date: _____

Name: _____ Age: _____ Sex: M F

Date of Birth: _____ Marital Status: Single Married Divorced Widow(er) Other

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Primary Care Physician: _____ **Referring Doctor:** _____

Occupation: _____ Employer: _____

Social Security Number (for insurance billing): _____

Individual responsible for bill (if other than patient): _____

Mobile Phone: _____ Landline: _____

Email address: _____

Primary Medical Insurance: _____

Secondary Insurance: _____

Subscriber's Name: _____ Subscriber's Date of Birth _____

Emergency contact person: _____

Phone: _____ Relationship: _____

Preferred pharmacy: _____ Location (street and city): _____

Please note: Tricare and the VA require a referral from your primary care doctor. Please include our fax number (808-315-7663) with your referral submission.

Notice of confidentiality practices

Important: This notice deals with the sharing of information from your medical records. Please read it carefully.

This notice describes your confidentiality rights as they relate to information from your medical records and explains the circumstances under which information from your medical records may be shared with others. The information in this notice also applies to others covered under your health plan, such as your spouse and children. If you do not understand the terms for this notice, please ask for further explanation (Chapter 323C HRS).

Your rights

Under the new law, you have the right to:

- Inspect and request copies of your medical records or to appeal any denial of your request for inspection or copying.
- Request that your health care provider append information to your medical record.
- Receive a notice of your privacy right by your health plan upon enrollment, annually, and when their confidentiality practices are substantially amended.
- Obtain a copy of this document, which describes our office’s confidentiality practices.

Uses of information

This office uses your protected health information to provide you with health care services. Under the law, your health information may be shared with physicians and other health care providers who are treating you. Your health information may also be used by such entities such as your health insurance plan for administrative and utilization management purposes. Except for the purposes outlined above, your health information may not be disclosed without your authorization.

Limiting disclosure of your protected health information

You have the right to limit disclosure of your protected health information if you choose not to use any health insurance or other third party payment as payment for services. If this is the case, you may only limit disclosure if you have advised the physician prior to the delivery of services and have paid for the health care services yourself.

My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Confidentiality Practices.

Name of Patient (please print) _____ Date _____

Signature of patient or legal representative _____ Date _____

If signed by legal representative, please state the relation to the patient

Communication with Family

This authorization gives Hawaii Vision Specialists permission to speak to immediate family members regarding my medical information and treatment:

YES NO
(Please circle one)

Additional persons with whom you authorize Hawaii Vision Specialists to communicate:

Name _____ Relationship _____

Name _____ Relationship _____

Our office will remind you prior to your appointment with your choice of a recorded voice message, email, or text. Please indicate your preference below:

- Email
- Text
- Voice message

Appointment scheduling and NO SHOW policy

Our office does its utmost to assist you in a timely fashion in all aspects of our services. To facilitate seeing you on-time, we do not over-book our schedule out of respect for your time. In turn, we expect patients who make appointments to keep those appointments or give adequate notice if rescheduling is needed. If you need to reschedule an appointment with our office, you must give 24 hours notice on a business day. You are considered late if you have not checked in within 15 minutes of your scheduled appointment time. Failure to give adequate notice will result in a NO SHOW that is subject to a fee that must be paid prior to you being re-scheduled. We reserve the right to dismiss patients from our practice who are repeat NO SHOW offenders.

Additional Fee Schedule:

- ◇ Transfer of records electronically or via fax to another physician's office: NO FEE
- ◇ Hard copy transfer or duplication of medical records: \$30
- ◇ Family leave request (FMLA) form: \$25
- ◇ Doctor's excuse for school or work: NO FEE
- ◇ Bureau of Motor Vehicles (DMV) form: \$10

If Hawaii Vision Specialists, LLP participates with your insurance(s), a claim will be filed for you. You will be responsible for any non-covered services and ultimately are responsible for your entire account, with or without insurance payments. By signing below, I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to Hawaii Vision Specialists, LLP the party responsible for acceptance of assignment from all payor sources.

Signature of Patient or Authorized Representative

Date _____

Please place a checkmark beside the main reason for your visit

Blurry spot in vision
Blurry vision
Bump on eyelid
Burning sensation
Crossed eyes
Diabetic Eye Exam
Discharge
Distorted Vision
Dizziness
Double Vision
Drooping lid
Dry eye
Eye lashes turning in
Flashes
Floaters
Foreign body sensation
Glare
Glasses check
Glaucoma Evaluation
Headaches
Itchy Eyelids
Itchy Eyes
Painful Eyes
Redness in the eyes
Routine Eye Exam
Problem after cornea transplant
Problem with contact lenses
Sudden loss of vision
Trauma to the eye
Wants to be free of glasses/contacts
Watery eyes

• How would you describe the quality of this problem?
(for example: cloudy, fuzzy, seeing halos, gritty, irritated)

• What makes it better or worse?

• When does it happen most often?

• Anything else you notice at the same time?

• How severe is it?

Not Minimal Mild Significant
Moderate Severe

• Where is it located?

Right eye Left eye

Other: _____

• When does it happen?

None intermittently constantly
occasionally only once

• How long has it been happening?

(for example: minutes, hours, days, weeks, months)

Please list any allergies to medicine or other things in the environment:

Allergic item	Reaction	Severity
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Please list any past surgeries you have had:

Surgery	Year
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Please list any medicines you take for the whole body (or please give us a list to copy if available):

Medicine	Dose	How many times a day	How long taking
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Please check if anyone in your family has any of the following conditions:

- Diabetes Stroke Blindness Macular Degeneration Arthritis
Cancer Tuberculosis Cataracts Retinal disease Lazy Eye
Heart disease Kidney disease Glaucoma High blood pressure
Other: _____

Please check your smoking status:

- Current everyday smoker
Current some day smoker
Former Smoker
Never Smoked
Smoker, current status unknown
Unknown if ever smoked

Do you drink alcohol? Yes No

- If yes, how much :**
- 1 glass of wine a day
2 glasses of wine a day
3 or more glasses of wine a day
1-3 beers/day
More than 3 beers/day
1-2 cocktails/day
3 or more cocktails/day

Do you use drugs? Yes No

If yes please check which:

- Cocaine
Heroin
Hydrocodone
Inhalants
LSD
Marijuana
Ecstasy
Methamphetamine
Oxycontin
Steroids

Please check one for each choice:

Eyes:	Y	N	Respiratory:	Y	N
Previous surgery	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>
Contact lens	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>			
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Blood/Lymph:	Y	N
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruise	<input type="checkbox"/>	<input type="checkbox"/>
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Gums bleed	<input type="checkbox"/>	<input type="checkbox"/>
Flashes	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Floaters	<input type="checkbox"/>	<input type="checkbox"/>	Heavy aspirin use	<input type="checkbox"/>	<input type="checkbox"/>

Gastrointestinal:

- Heartburn Y N
 Nausea/Vomiting Y N
 Jaundice/
 Hepatits Y N

Musculoskeletal:

- Stiffness Y N
 Arthritis Y N
 Joint pain/
 swelling Y N

Ear, Nose, Throat:

- Hard of hearing Y N
 Ringing in ears Y N
 Vertigo Y N

Genitourinary:

- Pain/difficulty Y N
 Blood in urine Y N
 History of kidney-
 stones Y N
 History of STDs Y N

Skin:

- Rash/Sores Y N
 Lesions Y N
 Hives/Eczema Y N

Cardiovascular:

- Chest Pain Y N
 Dizziness Y N
 Fainting spells Y N
 Shortness of breath Y N
 Irregular heart beat Y N
 Difficulty lying flat Y N

Psychiatric:

- Anxiety/depression Y N
 Mood swings Y N
 Difficulty sleep-
 ing Y N

Neurological:

- Seizures Y N
 Weakness/Paralysis Y N
 Numbness Y N
 Tremors Y N