Hawaii vision Specialists

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Miki'ala Souza, OD
Ocular Disease Specialist

Dan Driscoll, MD
Cornea, Cataract, and Refractive Surgery Specialist

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: Quest, 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 it's 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

- 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

Please list any previous eye problems:

Problem	Eye	Ongoing?

Please list any previous eye surgeries:

Surgery	Eye	Year

Please list any current eye medications you take:

Medication	Dosage	Eye	How often	How long taking

Please circle any of the following medical conditions you have:

Anemia	Gout	Rheumatoid Arthritis
Arrhythmia	Hepatitis	Sarcoidosis
Arteriosclerosis	HIV/AIDS	Seasonal Allergy
Asthma	High Cholesterol	Shingles
Atrial Fibrillation	High Blood Pressure	Sickle Cell
Benign Prostate Hypertrophy	Kidney Stones	Sinusitis
Cancer _____	Lupus	Sjogren's disease
Cardiovascular disease	Melanoma	Sleep Apnea
Cirrhosis	Meningitis	Stroke
Congestive heart failure	Migraine headache	Temporal Arteritis
COPD	Multiple Sclerosis	Thyroid…. Hyper or Hypo ?
Dementia	Osteoarthritis	Urinary Tract Infection
Depression	Osteoporosis	Other:
Diabetes Type I (juvenile)	Parkinson's Disease	
Diabetes Type II (adult onset)	Pregnancy	
Epilepsy	Pseudotumor cerebri	
GERD	Renal Insufficiency	Last blood sugar:

Please list any past surgeries you have had:

Surgery	Year

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

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
□Ecstacy
□Methamphetamine
□Oxycontin
□Steroids

Please check one for each choice:

Eyes:	Y	N
Previous surgery	☐	☐
Contact lens	☐	☐
Pain	☐	☐
Double Vision	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Macular Degeneration	☐	☐
Dry Eyes	☐	☐
Flashes	☐	☐
Floaters	☐	☐

Respiratory:	Y	N
Cough	☐	☐
Congestion	☐	☐
Wheezing	☐	☐
Asthma	☐	☐

Blood/Lymph:	Y	N
Easy Bruise	☐	☐
Gums bleed	☐	☐
Prolonged bleeding	☐	☐
Heavy aspirin use	☐	☐

Gastrointestinal:	Y	N
Heartburn	☐	☐
Nausea/Vomiting	☐	☐
Jaundice/ Hepatits	☐	☐

Musculoskeletal:	Y	N
Stiffness	☐	☐
Arthritis	☐	☐
Joint pain/ swelling	☐	☐

Ear, Nose, Throat:	Y	N
Hard of hearing	☐	☐
Ringing in ears	☐	☐
Vertigo	☐	☐

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

Skin:	Y	N
Rash/Sores	☐	☐
Lesions	☐	☐
Hives/Eczema	☐	☐

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

Psychiatric:	Y	N
Anxiety/depression	☐	☐
Mood swings	☐	☐
Difficulty sleep-ing	☐	☐

Neurological:	Y	N
Seizures	☐	☐
Weakness/Paralysis	☐	☐
Numbness	☐	☐
Tremors	☐	☐