

## Patient Registration Form

Patient Information - Please Print			
Last: _____	First: _____	Middle: _____	Title: _____
Address: _____		City, State, Zip: _____	
Date of Birth: _____	Gender: <input type="checkbox"/> F <input type="checkbox"/> M	Marital status: _____	Drivers Lic# _____
Primary Phone Number: _____	circle one:	Home	Cell    Work
Secondary Phone Number: _____	circle one:	Home	Cell    Work
Email: _____	SSN: _____		

Employment of Patient (or guardian)	Primary Care Physician
Employer: _____	Full Name: _____
Occupation: _____	Phone: _____
Work phone: _____	Address: _____
Spouse (or emergency contact) Information	Whom may we thank for sending you to our clinic?
Name _____ SSN: _____	Referred by Dr. _____
Employer: _____ DOB: _____	Referred by: <input type="checkbox"/> Patient <input type="checkbox"/> Friend <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Internet
Occupation: _____ Work Phone: _____	<input type="checkbox"/> Newspaper Ad <input type="checkbox"/> TV Ad <input type="checkbox"/> Radio Ad   Other: _____

Health Insurance information					
	Insurance Company	Subscriber Name	Relation	Subscriber #	Subscriber Birthdate
Primary	_____	_____	_____	_____	___/___/___
Secondary	_____	_____	_____	_____	___/___/___
Other	_____	_____	_____	_____	___/___/___
If Workers Comp - please fill out additional form available from check-in desk.					

### Important Information – Please Read and Sign Below

I hereby authorize Honolulu Eye Clinic and its doctors to release all medical information regarding my illness, care, and / or injury to my insurance carriers, any health care facility, and any other physician that would benefit my health care. I hereby assign Honolulu Eye Clinic and its doctors all payments to which I am entitled for medical / surgical expenses related to the services reported from the above.

I understand I am financially responsible to Honolulu Eye Clinic and its doctors for all charges, whether or not they are paid by said insurance. A photocopy of this assignment is as valid as the original.

Your eyes may be dilated for your eye exam. Dilation will make the pupils of your eyes large for several hours and can cause light sensitivity, glare, and blurred vision. Dark glasses are required. If you do not have your own, please ask us for a pair.

**Patient (or Guardian's) Signature** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

## Financial & Insurance Information Sheet

Our goal is to provide each patient with the finest medical care in a professional environment which inspires trust and confidence. Our office is a business that must be managed efficiently, if we are to continue serving our patients with quality care. Our fees are fair and reflect the care and expertise with which we treat each patient.

To keep our fees from rising considerably and to minimize the expenses of billing and bookkeeping, we offer our patients payment options.

**We ask that all co-payments be paid at the time services are rendered unless other arrangements have been made. Patients with no insurance coverage and out-of-state patients must pay in full for services before leaving the clinic. All contact lenses and glasses purchased through this office must be paid for in full at the time of order, and prior to dispensing.**

Please note that **Medicare and HMSA 65C+** limits the number of services or visits for which they will pay. It does not cover routine eye exams and any part of the exam that includes "refraction". If Medicare will not cover these services, you are responsible for payment. Please present ALL insurance cards to the receptionist so that we may make copies for our files.

We accept payment with cash, personal check, or credit card. If you choose to pay with your credit card, please fill out the credit / debit card authorization form completely. This information will be kept in a secured file. We understand that you may have medical insurance to cover your services. However, in the event of non-covered services, deductibles, co-payments, insurance cancellations, etc., you can pay with your credit / debit card. Payment plans are also available through this office.

### **SIGNATURE REQUIRED - Please read carefully and sign below**

- My signature below on this form constitutes a signature on file. This enables the Honolulu Eye Clinic and its physicians to submit insurance claims for benefits on my behalf without obtaining my signature.
- I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to make payment or denies any services, I will be responsible for the full amount owed.
- In the event that a collection agency or attorney has to be used to collect the amounts I owe the Honolulu Eye Clinic, I agree that I will be responsible for all costs incurred to collect from me using those services.
- I have received a Patient Privacy Statement from the Honolulu Eye Clinic.

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**Signature of Patient or Legal Guardian**

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**Date**

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**Print Name**

**CREDIT / DEBIT CARD AUTHORIZATION**

Credit Card / Debit Card Type:  Mastercard  Visa  
 Debit Card  American Express

Credit Card / Debit Card # \_\_\_\_\_

Expiration Date: \_\_\_\_\_ / \_\_\_\_\_  
Month Year

Name as it appears on the credit / debit card: \_\_\_\_\_  
Print Name

Credit Card Billing Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I give authorization to bill my card for any balance due on my account

I authorize a once only payment in the amount of \$ \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Medical History Questionnaire

Do you have now or have you recently had: (please check YES or NO)

Dates/Explain:	Dates/Explain:
Fever, chills, night sweats, unexplained fatigue? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Neurologic disease? <input type="checkbox"/> Y <input type="checkbox"/> N _____
Weight gain or loss over 10 lbs in the last year? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Stroke, seizures, tremor? <input type="checkbox"/> Y <input type="checkbox"/> N _____
Loss of vision <input type="checkbox"/> Y <input type="checkbox"/> N _____	Parkinson's disease? <input type="checkbox"/> Y <input type="checkbox"/> N _____
Blurred vision <input type="checkbox"/> Y <input type="checkbox"/> N _____	Memory loss, disorientation? <input type="checkbox"/> Y <input type="checkbox"/> N _____
Loss of side vision <input type="checkbox"/> Y <input type="checkbox"/> N _____	Anxiety, depression? <input type="checkbox"/> Y <input type="checkbox"/> N _____
Double vision <input type="checkbox"/> Y <input type="checkbox"/> N _____	Diabetes, date of onset? <input type="checkbox"/> Y <input type="checkbox"/> N _____
Dry eyes <input type="checkbox"/> Y <input type="checkbox"/> N _____	Thyroid disease? <input type="checkbox"/> Y <input type="checkbox"/> N _____
Eye discharge <input type="checkbox"/> Y <input type="checkbox"/> N _____	Adrenal or pituitary disease? <input type="checkbox"/> Y <input type="checkbox"/> N _____
Red eyes <input type="checkbox"/> Y <input type="checkbox"/> N _____	Blood disorders, anemia? <input type="checkbox"/> Y <input type="checkbox"/> N _____
Sandy or gritty eyes <input type="checkbox"/> Y <input type="checkbox"/> N _____	Easy bruising; clotting? <input type="checkbox"/> Y <input type="checkbox"/> N _____
Itchy eyes <input type="checkbox"/> Y <input type="checkbox"/> N _____	AIDS or HIV positive? <input type="checkbox"/> Y <input type="checkbox"/> N _____
Burning eyes <input type="checkbox"/> Y <input type="checkbox"/> N _____	Cancer or tumor, type, date? <input type="checkbox"/> Y <input type="checkbox"/> N _____
Eye foreign body sensation <input type="checkbox"/> Y <input type="checkbox"/> N _____	Are you pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N _____
Eye pain or soreness <input type="checkbox"/> Y <input type="checkbox"/> N _____	Expected delivery date? _____
Chronic infection of eyes <input type="checkbox"/> Y <input type="checkbox"/> N _____	Family History: Among your <b>blood relatives</b> , have they had:
Chronic infection of lids <input type="checkbox"/> Y <input type="checkbox"/> N _____	Blindness <input type="checkbox"/> Y <input type="checkbox"/> N _____
Tearing or watering eyes <input type="checkbox"/> Y <input type="checkbox"/> N _____	Cataracts <input type="checkbox"/> Y <input type="checkbox"/> N _____
Crossed eyes <input type="checkbox"/> Y <input type="checkbox"/> N _____	Glaucoma <input type="checkbox"/> Y <input type="checkbox"/> N _____
Lazy eye <input type="checkbox"/> Y <input type="checkbox"/> N _____	Macular degeneration <input type="checkbox"/> Y <input type="checkbox"/> N _____
Droopy eyelid(s) <input type="checkbox"/> Y <input type="checkbox"/> N _____	Retinal detachment or disease <input type="checkbox"/> Y <input type="checkbox"/> N _____
Ear, nose, throat problems, loss of hearing, smell? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Lazy eye or muscle imbalance <input type="checkbox"/> Y <input type="checkbox"/> N _____
Sinus, vertigo, dry mouth, difficulty swallowing? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Cancer or tumor <input type="checkbox"/> Y <input type="checkbox"/> N _____
Heart / circulation problems? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Diabetes mellitus <input type="checkbox"/> Y <input type="checkbox"/> N _____
Heart attack or angina? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Heart disease <input type="checkbox"/> Y <input type="checkbox"/> N _____
Congestive heart failure? <input type="checkbox"/> Y <input type="checkbox"/> N _____	High blood pressure <input type="checkbox"/> Y <input type="checkbox"/> N _____
Irregular heart beat? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Bleeding disorder <input type="checkbox"/> Y <input type="checkbox"/> N _____
Cardiac pacemaker or valve? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Other _____
High blood pressure? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Are you a smoker? <input type="checkbox"/> Y <input type="checkbox"/> N How many packs per day? _____
Respiratory problems? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Do you drink alcohol? <input type="checkbox"/> Y <input type="checkbox"/> N How many drinks per day? _____
Asthma; chronic cough? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Do you use drugs? <input type="checkbox"/> Y <input type="checkbox"/> N _____
Emphysema; bronchitis? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Have you had any <b>eye surgery, laser</b> , or injury? <input type="checkbox"/> Y <input type="checkbox"/> N
Tuberculosis or +PPD? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Names & dates of operation(s) or injuries: _____
Gastrointestinal problems? <input type="checkbox"/> Y <input type="checkbox"/> N _____	_____
Ulcers, diverticulitis, colitis? <input type="checkbox"/> Y <input type="checkbox"/> N _____	_____
Frequent diarrhea? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Eye drops/medications: _____
Liver disease, hepatitis? <input type="checkbox"/> Y <input type="checkbox"/> N _____	_____
Genitourinary disease? <input type="checkbox"/> Y <input type="checkbox"/> N _____	_____
Kidney, bladder problems? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Prescription & nonprescription medications: _____
Prostate, stones, infections? <input type="checkbox"/> Y <input type="checkbox"/> N _____	_____
Urinary frequency, STD? <input type="checkbox"/> Y <input type="checkbox"/> N _____	_____
Muscle weakness, fatigue? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Do you have any allergies to medication? <input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis, joint swelling? <input type="checkbox"/> Y <input type="checkbox"/> N _____	If "Yes", please list: _____
Low back pain, gout? <input type="checkbox"/> Y <input type="checkbox"/> N _____	_____
Rheumatoid / osteoarthritis? <input type="checkbox"/> Y <input type="checkbox"/> N _____	_____
Skin, hair, or nail problems? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Do you currently wear contact lenses? <input type="checkbox"/> Y <input type="checkbox"/> N
Eczema, psoriasis, rosacea? <input type="checkbox"/> Y <input type="checkbox"/> N _____	If yes, <input type="checkbox"/> Soft contacts <input type="checkbox"/> Rigid Gas Permeable (RGP)
Skin cancer, infections? <input type="checkbox"/> Y <input type="checkbox"/> N _____	Do you currently wear glasses? <input type="checkbox"/> Y <input type="checkbox"/> N

**Details regarding above YES answers:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_