

## Patient Registration Form

<b>Patient Information - Please Print</b>			
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: _____	

<b>Employment of Patient (or guardian)</b>	<b>Primary Care Physician</b>
Employer: _____	Full Name: _____
Occupation: _____	Phone: _____
Work phone: _____	Address: _____
<b>Spouse (or emergency contact) Information</b>	<b>Whom may we thank for sending you to our clinic?</b>
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: _____

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

**Financial and insurance information – PLEASE READ CAREFULLY**

- Please present ALL insurance cards to the receptionist so that we may make copies for our files.
- We participate with many insurance carriers and file your insurance claims. However, should your visit be denied by your insurance company, you will be responsible for the balance on your account. Payment in full is expected upon notification.
- If you do not have insurance or if you have an insurance plan for which we do not participate you must pay in full for your services before leaving the clinic. You are responsible for the costs of any products and services you receive from the clinic.
- All contact lenses and glasses purchased through this office must be paid for in full prior to dispensing.
- **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 your visits you are responsible for payment.

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

- All insurance claims filed by this office for me require my signature. By signing below I authorize the Honolulu Eye Clinic and its physicians to submit claims for benefits without obtaining my signature on each and every claim submitted for myself or my dependents and that I will be bound by this signature as though I had personally signed the particular claim.
- 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.

**Patient (or Guardian’s) 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 _____	<b>Family History: Among your blood relatives, have they had:</b>	
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 eye surgery, laser, 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 _____	Eye drops/medications:	_____
Frequent diarrhea?	<input type="checkbox"/> Y <input type="checkbox"/> N _____	_____	
Liver disease, hepatitis?	<input type="checkbox"/> Y <input type="checkbox"/> N _____	_____	
Genitourinary disease?	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Prescription & nonprescription medications:	_____
Kidney, bladder problems?	<input type="checkbox"/> Y <input type="checkbox"/> N _____	_____	
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:

---



---



---



---