

## Patient Registration Form

Patient information - please print	Visit information
Patient Last name _____ First name _____ Initial _____ Street address: _____ Title: _____ City: _____ St: _____ Zip: _____ Date of birth: ____/____/____ Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male Home phone: _____ Cell: _____ Social Security#: _____-____-_____ Email: _____	Date of visit: ____/____/____ <input type="checkbox"/> 1st visit - new patient <input type="checkbox"/> Return visit - former patient with updated information  <div style="background-color: #f0f0f0; padding: 2px;">             For office use only:              PC Doctor: <input type="checkbox"/>JW <input type="checkbox"/>RW <input type="checkbox"/>JB <input type="checkbox"/>_____           </div>

Family Physician (or Pediatrician):	Whom may we thank for sending you to our clinic?
Mailing Address: _____ Phone: _____ Fax: _____ Email: _____	<input type="checkbox"/> Referred by another doctor: _____ <input type="checkbox"/> Referred by patient <input type="checkbox"/> Referred by friend <input type="checkbox"/> Yellow Page Ad <input type="checkbox"/> Newspaper Ad <input type="checkbox"/> TV Ad <input type="checkbox"/> Radio Ad Other: _____
Name of Parent/Guardian #1:	Name of Parent/Guardian #2:
Name: _____ Daytime Phone: _____ Employer: _____ Cell Phone: _____ Occupation: _____ Email: _____	Name: _____ Daytime Phone: _____ Employer: _____ Cell Phone: _____ Occupation: _____ Email: _____

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.

### 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 examinations and any part of the exam that includes “refraction”. If Medicare will not cover your visits you are responsible for payment for them.

### 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.

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

# Pediatric Ophthalmology/Adult Strabismus - New Patient Questionnaire

**History of Eye Problems:**

Yes	No	Glasses/Contact lenses/Prisms	
<input type="checkbox"/>	<input type="checkbox"/>	Glasses	How old is current pair?
<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses	How old is current pair?
<input type="checkbox"/>	<input type="checkbox"/>	Hard, Gas permeable, or Soft?	Contact lens cleaning solutions:
<input type="checkbox"/>	<input type="checkbox"/>	Prisms	How long?

Yes	No	Other eye symptoms	Age or How Long?	Yes	No	Other eye symptoms	Age or How Long?
<input type="checkbox"/>	<input type="checkbox"/>	Eye exam by specialist		<input type="checkbox"/>	<input type="checkbox"/>	Eye injury	
<input type="checkbox"/>	<input type="checkbox"/>	Patching		<input type="checkbox"/>	<input type="checkbox"/>	Stye	
<input type="checkbox"/>	<input type="checkbox"/>	Eye exercises		<input type="checkbox"/>	<input type="checkbox"/>	Recurring "pink eye"	
<input type="checkbox"/>	<input type="checkbox"/>	Eye muscle surgery		<input type="checkbox"/>	<input type="checkbox"/>	Cataract	
<input type="checkbox"/>	<input type="checkbox"/>	Other eye surgery		<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetic eye disease		<input type="checkbox"/>	<input type="checkbox"/>	Other:	

**Recent Eye Symptoms:**

Yes	No	How long?	Yes	No	How long?
<input type="checkbox"/>	<input type="checkbox"/>	Crossed or wandering eye	<input type="checkbox"/>	<input type="checkbox"/>	Drooping eye lid
<input type="checkbox"/>	<input type="checkbox"/>	Excessive squinting	<input type="checkbox"/>	<input type="checkbox"/>	Tired eyes when reading
<input type="checkbox"/>	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Dry or gritty sensation
<input type="checkbox"/>	<input type="checkbox"/>	Excessive eye rubbing	<input type="checkbox"/>	<input type="checkbox"/>	Itching eyes
<input type="checkbox"/>	<input type="checkbox"/>	Frequent tearing or discharge	<input type="checkbox"/>	<input type="checkbox"/>	Red eyes
<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Flashing lights or floaters
<input type="checkbox"/>	<input type="checkbox"/>	Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Poor peripheral vision

Other eye symptoms not mentioned above:

**Other Recent Symptoms:**

Yes	No	Symptom	How long?	Yes	No	Symptom	How long?
<input type="checkbox"/>	<input type="checkbox"/>	Weight loss		<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea/constipation	
<input type="checkbox"/>	<input type="checkbox"/>	Excessive fatigue		<input type="checkbox"/>	<input type="checkbox"/>	Frequent/painful urination	
<input type="checkbox"/>	<input type="checkbox"/>	Fever		<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	
<input type="checkbox"/>	<input type="checkbox"/>	Earaches		<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	
<input type="checkbox"/>	<input type="checkbox"/>	Sore throat		<input type="checkbox"/>	<input type="checkbox"/>	Rash	
<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth		<input type="checkbox"/>	<input type="checkbox"/>	Headaches	
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain		<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	
<input type="checkbox"/>	<input type="checkbox"/>	Rapid heart rate		<input type="checkbox"/>	<input type="checkbox"/>	Numbness	
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath		<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of hands/feet		<input type="checkbox"/>	<input type="checkbox"/>	Memory loss	
<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite		<input type="checkbox"/>	<input type="checkbox"/>	Change in school performance	
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting		<input type="checkbox"/>	<input type="checkbox"/>	Clumsiness	

**Family History:** Which of the patient's *relatives* have had any of the following?

Yes	No	Eye Conditions in other family members:	Which relative? (Circle or fill in.)				
<input type="checkbox"/>	<input type="checkbox"/>	Glasses <b>before age 6</b>	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia ("lazy eye")	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Patching treatment	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Strabismus ("crossed" or "wandering" eye)	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Eye muscle surgery	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts <b>in childhood</b>	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma <b>in childhood</b>	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Blindness <b>in childhood</b>	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Eye disease caused by diabetes	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Macular degeneration	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Retinal detachment	Father	Mother	Sister	Brother	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Other serious eye disease <b>in childhood</b>	Father	Mother	Sister	Brother	Other:

Yes	No	Medical conditions in other family members:	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Complications from anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Genetic disease (runs in family)	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Other serious illnesses in family members:

**Medical History**

Yes	No	Condition	Yes	No	Condition	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic disease
<input type="checkbox"/>	<input type="checkbox"/>	Sinus disease	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or stroke
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Missing immunizations

Major illnesses or previous surgery not mentioned above (other than eye problems):

**Medications**

List any **eye drops** the patient is taking:                      List any **medications** the patient is taking:

Eye drop and frequency <input type="checkbox"/> NONE	Medication and dosage <input type="checkbox"/> NONE

**Birth history (Pediatric patients only):** Birth weight: \_\_\_\_ lb, \_\_\_\_ oz

Yes	No	Condition	Please provide details
<input type="checkbox"/>	<input type="checkbox"/>	Problems during pregnancy	Describe:
<input type="checkbox"/>	<input type="checkbox"/>	Problems during delivery	Describe:
<input type="checkbox"/>	<input type="checkbox"/>	Forceps delivery	
<input type="checkbox"/>	<input type="checkbox"/>	Cesarean section	
<input type="checkbox"/>	<input type="checkbox"/>	Delivered early	How many weeks?
<input type="checkbox"/>	<input type="checkbox"/>	Baby kept in hospital due to illness	Why and how long?

Reviewed by: Dr. \_\_\_\_\_ Date: \_\_\_\_\_