Honolulu Eye Clinic

Patient Registration Form

Patient Information - Please Print

Last: _____ First: _____ Middle:_____ Title:_____

Address: _____ City, State, Zip: _____

Date of Birth: _____ Gender: ☐F ☐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)

Employer:_____

Occupation:_____

Work phone:_____

Primary Care Physician

Full Name:_____

Phone:_____

Address:_____

Spouse (or emergency contact) Information

Name_____ SSN: _____

Employer:_____DOB:_____

Occupation:_____Work Phone:_____

Whom may we thank for sending you to our clinic?

Referred by Dr._____

Referred by: ☐Patient ☐Friend ☐Yellow Pages ☐Internet

☐Newspaper Ad ☐TV Ad ☐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:_____/_____/_____ REV 1/11

Honolulu Eye Clinic

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.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Print Name

Honolulu Eye Clinic

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

Honolulu Eye Clinic

Medical History Questionnaire

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

		Dates/Explain:
Fever, chills, night sweats, unexplained fatigue?	☐Y ☐N	
Weight gain or loss over 10 lbs in the last year?	☐Y ☐N	
Loss of vision	☐Y ☐N	
Blurred vision	☐Y ☐N	
Loss of side vision	☐Y ☐N	
Double vision	☐Y ☐N	
Dry eyes	☐Y ☐N	
Eye discharge	☐Y ☐N	
Red eyes	☐Y ☐N	
Sandy or gritty eyes	☐Y ☐N	
Itchy eyes	☐Y ☐N	
Burning eyes	☐Y ☐N	
Eye foreign body sensation	☐Y ☐N	
Eye pain or soreness	☐Y ☐N	
Chronic infection of eyes	☐Y ☐N	
Chronic infection of lids	☐Y ☐N	
Tearing or watering eyes	☐Y ☐N	
Crossed eyes	☐Y ☐N	
Lazy eye	☐Y ☐N	
Droopy eyelid(s)	☐Y ☐N	
Ear, nose, throat problems, loss of hearing, smell?	☐Y ☐N	
Sinus, vertigo, dry mouth, difficulty swallowing?	☐Y ☐N	
Heart / circulation problems?	☐Y ☐N	
Heart attack or angina?	☐Y ☐N	
Congestive heart failure?	☐Y ☐N	
Irregular heart beat?	☐Y ☐N	
Cardiac pacemaker or valve?	☐Y ☐N	
High blood pressure?	☐Y ☐N	
Respiratory problems?	☐Y ☐N	
Asthma; chronic cough?	☐Y ☐N	
Emphysema; bronchitis?	☐Y ☐N	
Tuberculosis or +PPD?	☐Y ☐N	
Gastrointestinal problems?	☐Y ☐N	
Ulcers, diverticulitis, colitis?	☐Y ☐N	
Frequent diarrhea?	☐Y ☐N	
Liver disease, hepatitis?	☐Y ☐N	
Genitourinary disease?	☐Y ☐N	
Kidney, bladder problems?	☐Y ☐N	
Prostate, stones, infections?	☐Y ☐N	
Urinary frequency, STD?	☐Y ☐N	
Muscle weakness, fatigue?	☐Y ☐N	
Arthritis, joint swelling?	☐Y ☐N	
Low back pain, gout?	☐Y ☐N	
Rheumatoid / osteoarthritis?	☐Y ☐N	
Skin, hair, or nail problems?	☐Y ☐N	
Eczema, psoriasis, rosacea?	☐Y ☐N	
Skin cancer, infections?	☐Y ☐N	

		Dates/Explain:
Neurologic disease?	☐Y ☐N	
Stroke, seizures, tremor?	☐Y ☐N	
Parkinson's disease?	☐Y ☐N	
Memory loss, disorientation?	☐Y ☐N	
Anxiety, depression?	☐Y ☐N	
Diabetes, date of onset?	☐Y ☐N	
Thyroid disease?	☐Y ☐N	
Adrenal or pituitary disease?	☐Y ☐N	
Blood disorders, anemia?	☐Y ☐N	
Easy bruising; clotting?	☐Y ☐N	
AIDS or HIV positive?	☐Y ☐N	
Cancer or tumor, type, date?	☐Y ☐N	
Are you pregnant?	☐Y ☐N	
Expected delivery date?		

Family History: Among your **blood relatives**, have they had:

Blindness	☐Y ☐N	
Cataracts	☐Y ☐N	
Glaucoma	☐Y ☐N	
Macular degeneration	☐Y ☐N	
Retinal detachment or disease	☐Y ☐N	
Lazy eye or muscle imbalance	☐Y ☐N	
Cancer or tumor	☐Y ☐N	
Diabetes mellitus	☐Y ☐N	
Heart disease	☐Y ☐N	
High blood pressure	☐Y ☐N	
Bleeding disorder	☐Y ☐N	
Other		

Are you a smoker? ☐Y ☐N How many packs per day?_____
Do you drink alcohol? ☐Y ☐N How many drinks per day?_____
Do you use drugs? ☐Y ☐N

Have you had any **eye surgery, laser**, or injury? ☐Y ☐N
Names & dates of operation(s) or injuries:_____

Eye drops/medications: _____

Prescription & nonprescription medications:_____

Do you have any allergies to medication? ☐Y ☐N
If "Yes", please list:_____

Do you currently wear contact lenses? ☐Y ☐N
If yes, ☐ Soft contacts ☐ Rigid Gas Permeable (RGP)
Do you currently wear glasses? ☐Y ☐N

Details regarding above YES answers:_____

REV 2/11

Doctor's Signature_____