New Patient Paperwork

PATIENT INFORMATION		
Patient Name:		☐ Male ☐ Female
Patient Nickname *(if applicable)*:		**DOB:**____/____/____
Email Address:		
Primary Phone:	**Cell Phone:**	
Mailing Address:		
City:	**State:**	**Zip Code:**

HOW DID YOU HEAR ABOUT EYESIGHT HAWAII
☐ Family/Friend ☐ Internet /Web Search ☐ Doctor Referral ☐ Location ☐ My Insurance_____
☐ I'm a former patient ☐ Newspaper ☐ TV ☐ Event_____ ☐ Other_____

EMERGENCY CONTACT INFORMATION	
Name:	**Relationship:**
Primary Phone:	**Email:**

CONTINUING CARE INFORMATION	
Pharmacy:	**Location:**
Current Primary Care Physician:	**Contact:**
Please list any other physicians that contribute to your health care that you would like us to be aware of:	
NAME AND CONTACT NUMBER	**SPECIALTY**

INSURANCE INFORMATION	
***Primary Insurance*:**	**Subscriber/Member Number:**
Subscriber's Name:	**Subscriber's DOB:**____/____/____ **Relationship:**
***Secondary Insurance*:**	**Subscriber/Member Number:**
Subscriber's Name:	**Subscriber's DOB:**____/____/____ **Relationship:**
***Vision / Other Insurance*:**	**Subscriber/Member Number:**
Subscriber's Name:	**Subscriber's DOB:**____/____/____ **Relationship:**

HIPPA, Consents and Policies

$25 CANCELLATION, NO-SHOW AND LATE ARRIVAL FEE / POLICY

EyeSight Hawaii strives to provide excellent individualized medical care in a timely manner. We make every effort to maintain appointment times. We understand special circumstances may cause you to arrive late, miss your appointment or cancel your appointment with only 24 hour notice. Fees in these instances may be waived, but only with management approval. Fees are the sole responsibility of the patient or responsible party and must be paid in full at the rescheduled appointment.

CANCELLED APPOINTMENTS Appointments which are cancelled with less than 24 hours will be put on a list. After three (3) appointment cancellations that are done less than 24 hours, a **$25.00 cancellation fee** will be charged per visit.

Patient Initials_____

NO-SHOW Patients who do not show up for their appointments without a call to cancel the appointment will be considered a **NO-SHOW** and will be put on a list. After two (2) no shows, a **$25.00 no-show fee** will be charged per missed appointment. **FAILURE TO KEEP SCHEDULED APPOINTMENTS** may result in the termination of physician-patient relationship.

Patient Initials_____

LATE ARRIVALS If you are running late, please call the office. Patients who arrive more than 15 minutes late for their scheduled appointment may need to reschedule to allow the other patients to be seen in a timely fashion.

Patient Initials_____

AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION (HIPAA CONSENT)

I authorize EyeSight Hawaii to disclose my health care, appointment, billing and medications/prescriptions information to those that I designate. I designate the following individuals for disclosure of patient health information as described above for my health care, appointment, billing and medications/prescriptions.

Patient Initials_____

Name_____ Relationship_____ Phone Number (_____)_____- _____

Name_____ Relationship_____ Phone Number (_____)_____- _____

Name_____ Relationship_____ Phone Number (_____)_____- _____

NOTICE OF PRIVACY PRACTICES

I acknowledge and agree that I have the right to review and can keep a copy of the “Notice of Privacy Practices” for review and to keep for my records.

I understand that EyeSight Hawaii may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and accounting information) to another party to permit EyeSight Hawaii to perform its administrative duties, provide me with eye care services and products, process my vision and eye medical benefit claims and communicate with me regarding vision and eye health services provided by EyeSight Hawaii (for example, communications regarding eye exams or information about news and services by EyeSight Hawaii).

I can be assured that EyeSight Hawaii does not sell my personal health information of any kind to a third party for such party’s use. Please Note: It is your right to refuse to sign this Acknowledgement.

Patient Initials_____

FINANCIAL POLICY

I hereby authorize to release any medical information required during the course of examination and treatment to my insurance company, and I permit payment to EyeSight Hawaii from my insurance for any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes, but is not limited to, coinsurance, copayment, deductible and non-covered services. I understand that I am responsible for all charges incurred regardless of insurance status. I agree to pay my bill for services rendered by EyeSight Hawaii.

Patient Initials_____

Signature of Patient or Legal Guardian:_____ Today’s Date:____/_____/_____

Communications Consent Form

Consent to Phone, Email, or Text Usage for Appointment Reminder and Other Healthcare Communication: Patients in our practice may be contacted via phone, email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our EyeSight Hawaii team, to provide general health reminders and practice news/information.

TEXT MESSAGE

_____ *(Patient Initials)* I consent to receive text message reminders from EyeSight Hawaii on my cell phone.

- *Cell Phone Number:* The cell phone number that I authorize to receive text message reminders for my appointment is (_____)_____-_____.
- The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan *(contact your carrier for pricing plans and details).*

_____ *(Patient Initials)* I decline to receive text message reminders from EyeSight Hawaii.

EMAIL MESSAGE

_____ *(Patient Initials)* I consent to receive email reminders from EyeSight Hawaii.

- The email that I authorize to receive email reminders for my appointment is_____.

_____ *(Patient Initials)* I decline to receive email reminders from EyeSight Hawaii.

PHONE MESSAGE

_____ *(Patient Initials)* I consent to receive phone call reminders from EyeSight Hawaii on my primary phone.

- *Primary Phone Number:* The phone number that I authorize to receive phone call reminders for my appointment is: (_____)_____-_____.
- I *do*_____, I *do not*_____, give permission to leave relevant medical information on my answering machine or voicemail.
- I *do*_____, I *do not*_____, want relevant medical information shared with the person who may answer the phone. The name(s) of the individual(s) with whom you may leave phone messages and pertinent information are:

Name_____ Contact Number (_____)_____-_____

Name_____ Contact Number (_____)_____- _____

_____ *(Patient Initials)* I decline to receive phone call reminders from EyeSight Hawaii.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize by healthcare provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication. I also authorize my healthcare provider to disclose such third parties limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voicemail or answering system if I am unavailable at the number provided by me.

Patient Printed Name_____ Date of Birth:____ /____ /_____

Patient Signature_____ Today's Date:____ /____ /_____

Ocular Surface Disease Index© (OSDI©)[2]

Ask your patient the following 12 questions, and circle the number in the box that best represents each answer. Then, fill in boxes A, B, C, D, and E according to the instructions beside each.

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING *DURING THE LAST WEEK*:

	All of the time	Most of the time	Half of the time	Some of the time	None of the time
1. Eyes that are sensitive to light?	4	3	2	1	0
2. Eyes that feel gritty?	4	3	2	1	0
3. Painful or sore eyes?	4	3	2	1	0
4. Blurred vision?	4	3	2	1	0
5. Poor vision?	4	3	2	1	0

Subtotal score for answers 1 to 5 (A)

HAVE PROBLEMS WITH YOUR EYES LIMITED YOU IN PERFORMING ANY OF THE FOLLOWING *DURING THE LAST WEEK*:

	All of the time	Most of the time	Half of the time	Some of the time	None of the time	
6. Reading?	4	3	2	1	0	N/A
7. Driving at night?	4	3	2	1	0	N/A
8. Working with a computer or bank machine (ATM)?	4	3	2	1	0	N/A
9. Watching TV?	4	3	2	1	0	N/A

Subtotal score for answers 6 to 9 (B)

HAVE YOUR EYES FELT UNCOMFORTABLE IN ANY OF THE FOLLOWING SITUATIONS *DURING THE LAST WEEK*:

	All of the time	Most of the time	Half of the time	Some of the time	None of the time	
10. Windy conditions?	4	3	2	1	0	N/A
11. Places or areas with low humidity (very dry)?	4	3	2	1	0	N/A
12. Areas that are air conditioned?	4	3	2	1	0	N/A

Subtotal score for answers 10 to 12 (C)

ADD SUBTOTALS A, B, AND C TO OBTAIN D (D = SUM OF SCORES FOR ALL QUESTIONS ANSWERED) (D)

TOTAL NUMBER OF QUESTIONS ANSWERED (DO NOT INCLUDE QUESTIONS ANSWERED N/A) (E)

Patient Name (Print)_____ Date_____

Patient Signature_____

MEDICAL HISTORY

PATIENT NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____

PLEASE COMPLETE THE FOLLOWING QUESTIONS REGARDING YOUR MEDICAL HEALTH HISTORY:

Who referred you here today: Name: _____ Phone: _____

Who are your medical doctors: What are you being treated for:

Name: _____ Treatment: _____ Phone: _____

_____ _____ _____

_____ _____ _____

Who is your Eye doctor? _____ Last seen: _____

What eye problems have you had in the past?

_____

Cataract Surgery: RT Eye ____ LT Eye ____ M.D. Name: _____

Retinal Surgery: RT Eye ____ LT Eye ____ M.D. Name: _____

Procedure: _____

Glaucoma: RT Eye ____ LT Eye ____ Prior Treatment: _____

Macular Degeneration: RT Eye ____ LT Eye ____ Prior Treatment: _____

Diabetic Retinopathy: RT Eye ____ LT Eye ____ Prior Treatment: _____

Eye Medications? (name of drops, strength, dosage, etc.)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

What other medications are you on? (pills, ointments, vitamins, name of medication, strength, dosage)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Allergies: __ None __Penicillin __ Sulfa __ Fluorescein __ Iodine Dye __ Shellfish

__ Other: _____

Reaction to Allergies: _____

What other surgeries (non-eye) related and hospitalizations have you had within past 10 years?

1) _____ Date: _____ 2) _____ Date: _____

3) _____ Date: _____ 4) _____ Date: _____

REVIEW OF SYSTEMS

PATIENT NAME: _____ DATE OF BIRTH: _____

***PLEASE CHECK ANY PROBLEM AREA AND EXPLAIN IN COMMENTS BOX IMMEDIATELY FOLLOWING PARTICULAR SUBJECT. CHECK "NO" IF YOU HAVE NOT HAD ANY PROBLEM.

General (constitutional)

YES NO

____ ____ weight loss
____ ____ lack of energy
____ ____ trouble sleeping
____ ____ other _____

Comments: _____

Eyes

____ ____ vision loss
____ ____ any changes in vision
____ ____ eye pain
____ ____ other _____

Comments: _____

Ears, Nose, Mouth, Throat

____ ____ hearing loss
____ ____ sinus problems
____ ____ infections
____ ____ other _____

Comments: _____

Heart & Blood Vessels (cardiovascular)

____ ____ heart attack
____ ____ high blood pressure
how long? _____
last blood pressure _____
____ ____ heart murmur
____ ____ irregular heart beat
____ ____ mitral valve prolapse

Comments: _____

Lungs (respiratory)

____ ____ asthma
____ ____ bronchitis
____ ____ shortness of breath
____ ____ emphysema
____ ____ Tuberculosis
____ ____ other _____

Comments: _____

Stomach & Intestines (gastrointestinal)

____ ____ ulcers
____ ____ diverticulitis
____ ____ constipation
____ ____ hepatitis
____ ____ other _____

Comments: _____

Kidneys, Bladder, Prostate (genitourinary)

YES NO

____ ____ kidney infections
____ ____ urinary infections
____ ____ hepatitis
____ ____ other _____

Comments: _____

Bones, Joints, Muscle (musculoskeletal)

____ ____ osteoporosis
____ ____ arthritis
____ ____ muscle pain
____ ____ other _____

Comments: _____

Skin/Breast (integumentary)

____ ____ Keloid, scarring
____ ____ rashes, sensitivities
____ ____ skin cancer
____ ____ other _____

Comments: _____

Nervous System (neurological)

____ ____ seizures
____ ____ stroke
____ ____ paralysis/weakness
____ ____ numbness
____ ____ migraines
____ ____ other _____

Comments: _____

Endocrine System

____ ____ Diabetes
how long? _____ insulin? _____
last blood sugar? _____test at home? _____
Are you on kidney dialysis? _____
____ ____ thyroid
____ ____ high cholesterol

Comments: _____

Blood (hematological/lymphatic)

____ ____ anemia
____ ____ excessive bleeding
____ ____ bruising easily
____ ____ clotting problems
____ ____ other _____

Allergic/Immunologic

____ ____ seasonal allergies
____ ____ HIV
____ ____ other _____

SOCIAL & FAMILY HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

SOCIAL HISTORY:

What is your occupation? _____ Are you still working? _____

Do you smoke cigarettes? _____ How much? _____ How frequently? _____

Do you drink alcohol? _____ Occasional/Social? _____ How much? _____ How frequently? _____

Past and/or present drug use (legal or illegal) is important for drug and anesthetic interactions. Please indicate if we need to be aware of this: ____ Yes ____No

FAMILY MEDICAL HISTORY:

Have any of your family (parents, siblings, or relatives) had any of the following medical problems? Please check "yes" or "no" for each problem and list who had that condition:

Yes	No		Yes	No	
____	____	Diabetes _____	____	____	Tuberculosis _____
____	____	Thyroid disease _____	____	____	Heart Disease _____
____	____	Stroke _____	____	____	High Blood Pressure _____
____	____	Anemia _____	____	____	Kidney disease _____
____	____	Hepatitis _____	____	____	Bleeding disease _____
____	____	Cancer (type) _____	____	____	Other _____

FAMILY EYE HISTORY:

Have any members of your family (parents, siblings, or relatives) had any of the following eye problems:

Yes	No		Yes	No	
____	____	Retinal Detachment _____	____	____	Glaucoma _____
____	____	Diabetic Retinopathy _____	____	____	Cataract _____
____	____	Macular Degeneration _____	____	____	Other _____

Is there anything not mentioned on this form that you would like the doctors to be aware of?

_____

Your eyes will be dilated for your 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 recommended. If you do not have your own, please ask us for a pair.

Patient's Signature: _____ Date: _____

_____

(M.D. initials)

PATIENT RESPONSIBILITY FORM

1. **INDIVIDUAL'S FINANCIAL RESPONSIBILITY**

- I understand that I am financially responsible for my health insurance deductible, co-insurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

1. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

- I hereby authorize and direct payment of my medical benefits to Eyesight Hawaii on my behalf for any services furnished to me by the providers.

2. AUTHORIZATION TO RELEASE RECORDS

- I hereby authorize Eyesight Hawaii to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization, or referral to other medical provider.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party **Date**

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party **Relationship to Patient**