



New Patient Paperwork

PATIENT INFORMATION		
Patient Name:	<input type="checkbox"/> Male <input type="checkbox"/> 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	
<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Internet /Web Search
<input type="checkbox"/> Doctor Referral	<input type="checkbox"/> Location
<input type="checkbox"/> My Insurance _____	
<input type="checkbox"/> I'm a former patient	<input type="checkbox"/> Newspaper
<input type="checkbox"/> TV	<input type="checkbox"/> Event _____
<input type="checkbox"/> Other _____	

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

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

INSURANCE INFORMATION	
<u>Primary Insurance:</u>	Subscriber/Member Number:
Subscriber's Name:	Subscriber's DOB: ____ / ____ / ____ Relationship:
<u>Secondary Insurance:</u>	Subscriber/Member Number:
Subscriber's Name:	Subscriber's DOB: ____ / ____ / ____ Relationship:
<u>Vision / Other Insurance:</u>	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: Name: _____ What are you being treated for: 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.)

Four horizontal lines for listing eye medications.

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

Four horizontal lines for listing other medications.

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**