EYESIGHT HAWAII

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:**

EYESIGHT HAWAII

HIPAA, 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 ☐

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 ☐

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 ☐

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

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

Patient Name (Print)_____ Date_____

Patient Signature_____

EYESIGHT HAWAII
VISION INSTITUTE

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: _____

Patient Name: _____ Date: _____

Review of Systems

Cardiovascular System
YES NO
____ ____ high blood pressure
____ ____ chest pain
____ ____ shortness of breath
____ ____ irregular heart beat

Constitutional System
YES NO
____ ____ fever
____ ____ weight loss
____ ____ fatigue
____ ____ loss of appetite
____ ____ fall risk

Endocrine System
YES NO
____ ____ diabetes
____ ____ thyroid
____ ____ high cholesterol
____ ____ heat intolerance
____ ____ cold intolerance

Gastrointestinal System
YES NO
____ ____ abdominal pain
____ ____ nausea
____ ____ hepatitis
____ ____ ulcers

Genitourinary System
YES NO
____ ____ kidney infection
____ ____ urinary infection
____ ____ pain/burning in urination
____ ____ blood in urine

Allergic/Immunological System
YES NO
____ ____ seasonal allergies
____ ____ HIV

Hematologic/Lymphatic System
YES NO
____ ____ anemia
____ ____ easy bruising
____ ____ prolonged bleeding
____ ____ clotting problems

H.E.N.T System
YES NO
____ ____ hearing loss
____ ____ sore throat
____ ____ sinus problems
____ ____ infections

Integumentary System
YES NO
____ ____ rash, sensitivities
____ ____ change in mole
____ ____ keloid, scarring
____ ____ skin cancer

Musculoskeletal System
YES NO
____ ____ muscle aches
____ ____ joint pain
____ ____ osteoporosis
____ ____ arthritis

Neurological System
YES NO
____ ____ weakness
____ ____ headaches/migraines
____ ____ scalp tenderness
____ ____ dizziness
____ ____ paralysis

Respiratory System
YES NO
____ ____ wheezing
____ ____ coughing

SOCIAL & FAMILY HISTORY

SOCIAL HISTORY:

Material Status: ____ Single ____ Married ____ Divorced ____ Widowed

What is your occupation? _____ Are you still working? _____
Do you smoke cigarettes? _____ How much? _____ History of smoking?_____
Do you drink alcohol? _____ Occasional/Social? _____ How much? _____
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: _____

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**