EYE CENTER OF HAWAI'I

Patient Information

Last Name: _____ First Name: _____ MI: _____

DOB: _____ SS#: _____

❑ Male ❑ Female ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Email: _____ Occupation: _____

Employer: _____ Work Phone: _____

Preferred Method of Contact: ❑ Home ❑ Work ❑ Mobile ❑ Email

Emergency Contact: _____

Relationship: _____ Phone: _____

Primary Insurance: _____ Subscriber: _____

Subscriber #: _____ Relationship: _____ DOB: _____

Medical Coverage or Group: _____ Employer: _____

Secondary Insurance: _____ Subscriber: _____

Subscriber #: _____ Relationship: _____ DOB: _____

Medical Coverage or Group: _____ Employer: _____

Other Insurance: _____ Subscriber: _____

Subscriber #: _____ Relationship: _____ DOB: _____

Medical Coverage or Group: _____ Employer: _____

Office Use Only

Date: _____ Int: _____ Date: _____ Int: _____ Date: _____ Int: _____

Date: _____ Int: _____ Date: _____ Int: _____ Date: _____ Int: _____

Date: _____ Int: _____ Date: _____ Int: _____ Date: _____ Int: _____

1620 Ala Moana Boulevard
Suite 500 | Honolulu, HI 96815
(808) 955-0255

98-1247 Kaahumanu Street
Suite 310 | Aiea, HI 96701
(808) 955-0255

94-216 Farrington Highway
Suite B2-203 | Waipahu, HI 96797
(808) 671-4778

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City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Email: _____ Occupation: _____

Employer: _____ Work Phone: _____

Preferred Method of Contact: ❑ Home ❑ Work ❑ Mobile ❑ Email

Emergency Contact: _____

Relationship: _____ Phone: _____

Primary Insurance: _____ Subscriber: _____

Subscriber #: _____ Relationship: _____ DOB: _____

Medical Coverage or Group: _____ Employer: _____

Secondary Insurance: _____ Subscriber: _____

Subscriber #: _____ Relationship: _____ DOB: _____

Medical Coverage or Group: _____ Employer: _____

Other Insurance: _____ Subscriber: _____

Subscriber #: _____ Relationship: _____ DOB: _____

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Email: _____ Occupation: _____

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Preferred Method of Contact: ❑ Home ❑ Work ❑ Mobile ❑ Email

Emergency Contact: _____

Relationship: _____ Phone: _____

Primary Insurance: _____ Subscriber: _____

Subscriber #: _____ Relationship: _____ DOB: _____

Medical Coverage or Group: _____ Employer: _____

Secondary Insurance: _____ Subscriber: _____

Subscriber #: _____ Relationship: _____ DOB: _____

Medical Coverage or Group: _____ Employer: _____

Other Insurance: _____ Subscriber: _____

Subscriber #: _____ Relationship: _____ DOB: _____

Medical Coverage or Group: _____ Employer: _____

Office Use Only

Date: _____ Int: _____ Date: _____ Int: _____ Date: _____ Int: _____

Date: _____ Int: _____ Date: _____ Int: _____ Date: _____ Int: _____

Date: _____ Int: _____ Date: _____ Int: _____ Date: _____ Int: _____

Preferred Pharmacy: _____

Who referred you to us? _____

Please list all of your medical providers:

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

Do you smoke? ❍ Yes ❍ No How much/often? _____

Do you drink alcohol? ❍ Yes ❍ No How much/often? _____

Do you exercise? ❍ Yes ❍ No How much/often? _____

Do you have any allergies to medications? ❍ Yes ❍ No What medications? _____

Do you have any allergies to iodine/shellfish? ❍ Yes ❍ No What medications? _____

Do you have any allergies to to latex? ❍ Yes ❍ No What medications? _____

Do you have any other allergies? ❍ Yes ❍ No What medications? _____

EYE HISTORY

Do you have a history of:

Diabetic Retinopathy ❍ Yes ❍ No Treatment: _____

Macular Degeneration ❍ Yes ❍ No Treatment: _____

Retinal Detachment ❍ Yes ❍ No Treatment: _____

Glaucoma ❍ Yes ❍ No Treatment: _____

Cataracts ❍ Yes ❍ No Treatment: _____

Laser Surgery ❍ Yes ❍ No Treatment: _____

Other: _____ ❍ Yes ❍ No Treatment: _____

SURGICAL HISTORY

List all surgeries, treatments, procedures and implants you have had:

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

MEDICAL HISTORY

Please check yes and provide the date of diagnosis for any medical problems you presently have or have had in the past, otherwise, check no.

General

			Year Diagnosed
Weight loss	❍ Yes	❍ No	
Lack of energy	❍ Yes	❍ No	
Trouble sleeping	❍ Yes	❍ No	
Other	❍ Yes	❍ No	

Eyes

Vision loss	❍ Yes	❍ No	
Changes in vision	❍ Yes	❍ No	
Eye pain	❍ Yes	❍ No	
Other	❍ Yes	❍ No	

Ears, Nose, Mouth & Throat

Hearing loss	❍ Yes	❍ No	
Sinus problems	❍ Yes	❍ No	
Infections	❍ Yes	❍ No	
Other	❍ Yes	❍ No	

Cardiovascular

Heart attack	❍ Yes	❍ No	
High blood pressure	❍ Yes	❍ No	
Heart murmur	❍ Yes	❍ No	
Irregular heart beat	❍ Yes	❍ No	
Mitral valve prolapse	❍ Yes	❍ No	
Chest pain	❍ Yes	❍ No	
Circulation problems	❍ Yes	❍ No	
Other	❍ Yes	❍ No	

Respiratory

Asthma	❍ Yes	❍ No	
Bronchitis	❍ Yes	❍ No	
Shortness of breath	❍ Yes	❍ No	
Emphysema	❍ Yes	❍ No	
Tuberculosis	❍ Yes	❍ No	
Other	❍ Yes	❍ No	

Gastrointestinal

Ulcers	❍ Yes	❍ No	
Diverticulitis	❍ Yes	❍ No	
Constipation	❍ Yes	❍ No	
Hepatitis	❍ Yes	❍ No	
Other	❍ Yes	❍ No	

Genitourinary

			Year Diagnosed
Kidney infections	❍ Yes	❍ No	
Urinary infections	❍ Yes	❍ No	
Cancer	❍ Yes	❍ No	
Prostate	❍ Yes	❍ No	
Other	❍ Yes	❍ No	

Bones, Joints & Muscle

Osteoporosis	❍ Yes	❍ No	
Arthritis	❍ Yes	❍ No	
Muscle pain	❍ Yes	❍ No	
Other	❍ Yes	❍ No	

Integumentary

Keloid/scarring	❍ Yes	❍ No	
Skin rash/sensitivity	❍ Yes	❍ No	
Skin cancer	❍ Yes	❍ No	
Other	❍ Yes	❍ No	

Nervous System

Seizure	❍ Yes	❍ No	
Stroke	❍ Yes	❍ No	
Paralysis/weakness	❍ Yes	❍ No	
Numbness	❍ Yes	❍ No	
Migraines	❍ Yes	❍ No	
Other	❍ Yes	❍ No	

Endocrine System

Diabetes	❍ Yes	❍ No	
Kidney dialysis	❍ Yes	❍ No	
Thyroid	❍ Yes	❍ No	
High cholesterol	❍ Yes	❍ No	

Blood

Anemia	❍ Yes	❍ No	
Excessive bleeding	❍ Yes	❍ No	
Bruising	❍ Yes	❍ No	
Clotting problems	❍ Yes	❍ No	
Other	❍ Yes	❍ No	

Immunologic

Lupus	❍ Yes	❍ No	
Rheumatoid arthritis	❍ Yes	❍ No	
HIV	❍ Yes	❍ No	
Other	❍ Yes	❍ No	

MEDICATIONS

Please list all medications you are currently taking, including non-prescription medications and vitamins:

Medication	Dose	How often	Reason for use

FAMILY MEDICAL HISTORY

Have any members of your family (parents, siblings, grandparents) had any of the following medical problems:

If yes, please indicate who has the condition

Diabetes	❍ Yes ❍ No	_____	Tuberculosis	❍ Yes ❍ No	_____
Thyroid disease	❍ Yes ❍ No	_____	Heart disease	❍ Yes ❍ No	_____
Stroke	❍ Yes ❍ No	_____	High blood pressure	❍ Yes ❍ No	_____
Anemia	❍ Yes ❍ No	_____	Kidney disease	❍ Yes ❍ No	_____
Hepatitis	❍ Yes ❍ No	_____	Bleeding disease	❍ Yes ❍ No	_____
Cancer	❍ Yes ❍ No	_____	Other	❍ Yes ❍ No	_____

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

Retinal detachment	❍ Yes ❍ No	_____	Glaucoma	❍ Yes ❍ No	_____
Diabetic retinopathy	❍ Yes ❍ No	_____	Cataract	❍ Yes ❍ No	_____
Macular degeneration	❍ Yes ❍ No	_____	Other	❍ Yes ❍ No	_____

Your eyes will 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, especially up close. Dark glasses are recommended. If you do not have your own please ask us for a pair.

_____ _____

Patient or Representative Signature Date

EYE CENTER OF HAWAI'I

Billing Procedures

We will be unable to bill your insurance unless we have a current insurance card or a completed insurance form for each insurance carrier. We will make every effort, on your behalf, to collect payment from your insurance company first. You are responsible for any co-payment at the time of service. To keep your costs as low as possible, we ask that you assist us with our billing procedures.

Medicare Patients: Our physicians are Medicare participating providers. This means that we will bill Medicare the Medicare allowed fee with the remaining 20% payable by you or your Medicare supplement insurance. Medicare patients are also responsible for the annual Medicare deductible and all non-covered services. All patient portions are payable at the time of service.

Participating Insurance Plans: All charges will be billed. All patient portions and non-covered services will be collected on the day of your visit.

Managed Care Plans (HMO): Our doctors are participating providers with many Managed Care Insurance Plans. If you are a member of one of these plans, we will ask you for a referral form from your primary care physician. You will be responsible for any co-payment and non-covered services, which are payable at the time of service. The balance will be billed directly to your insurance company.

Medicaid: You must have your current Medicaid card. All charges will be billed. All patient portions and non-covered services will be collected on the day of your visit.

Non-Participating Insurance: If you have insurance with a private carrier, we will make every effort to bill your insurance company first. You will be responsible for all charges incurred, payable at the time of your visit. Your private insurance company will reimburse you directly. Any such request must be accompanied by a completed insurance form at each visit, unless your insurance carrier accepts the standard HCFA 1500 form.

Non-Covered Services and Taxes: There are some services, as well as taxes, that your medical insurance may not cover at all and payment for these services and taxes are your responsibility. Payment for these non-covered services and taxes are collected at the time of your visit.

Payments, deductibles, other: All payments that are your responsibility are due at the time services are rendered. Cash, VISA, MasterCard, Discover, AMEX or personal check from a local bank is accepted. There will be a $20 service charge for all returned checks. In the event your account becomes delinquent, you are responsible for all additional charges incurred.

While filing of insurance claims is a courtesy that we extend to our patients, some charges such as deductibles and co-payments are your responsibility. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we ask that you contact us promptly for assistance with the management of your account.

The care of your eyes and your vision are our primary concern. Should you have any questions concerning this policy, please feel free to contact us at (808) 955-0255.

Authorization: I certify that the information I have provided to Eye Center of Hawai'i is true and correct. I understand that I am responsible for all charges for services provided by the Eye Center of Hawai'i. I authorize release of any information from my files, including, but not limited to, my medical and financial records necessary to process my insurance claims and request payment of insurance benefits to either myself or the party who accepts assignment/participation with my insurance company.

Patient/Representative Signature Date

Medicare/Medigap Long-Term Authorization: I request that payment of authorized Medicare/Medigap benefits be made either to myself or on my behalf to Eye Center of Hawai'i for any services, current or future, provided to me by the Eye Center of Hawai'i. I authorize Eye Center of Hawai'i to release to the Health Care Financing Administration and its agents, information needed from my files including, but not limited to, my medical and financial records for determination of benefits and/or the benefits payable for related services.

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1620 Ala Moana Boulevard
Suite 500 | Honolulu, HI 96815
(808) 955-0255

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Medicare Patients: Our physicians are Medicare participating providers. This means that we will bill Medicare the Medicare allowed fee with the remaining 20% payable by you or your Medicare supplement insurance. Medicare patients are also responsible for the annual Medicare deductible and all non-covered services. All patient portions are payable at the time of service.

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