Hawaiian Eye CENTER

www.hawaiianeye.com

606 Kilani Avenue, Wahiawa, HI 96786 (808)621-8448 Fax: (808)621-2082

94-673 Kupuohi Street, Suite C203, Waipahu, HI 96797 (808)678-0622 Fax: (808)678-0037

Patient Name: _____ Date of Birth: _____

Address: _____City: _____State: _____Zip Code: _____

SSN: _____E-Mail: _____

Cellphone No: _____ Primary No: _____ Work No: _____

Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Divorced ☐Widow Retired: ☐Yes ☐No

Employer/Address: _____ Occupation: _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown

Race: ☐ Asian ☐ American Indian ☐ Alaska White ☐ African American ☐ Pacific Islander

Referred By: ☐ Friend ☐ Family ☐ Optometrist: _____ ☐ Website ☐ Other:_____

May we send a thank you for your referral? ☐ Yes, who _____ ☐ No

Primary Care Physician: _____ Eye Doctor/Optometrist: _____

INSURANCE INFORMATION

Please have ready your insurance card and form of ID at the time of your appointment

Primary Ins: _____Subscriber's Name/ID #: _____ Date of Birth: _____

Secondary Ins: _____Subscriber's Name/ID #: _____ Date of Birth: _____

Tertiary Ins: _____Subscriber's Name/ID #: _____ Date of Birth: _____

Responsible Party (if other than the patient): _____ Date of Birth: _____

I hereby authorize Hawaiian Eye Center Doctors to release to my insurance company or representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I assign my insurance benefits including Medicare, HMSA, and or any other commercial health insurance plan payable to Steven Rhee, D.O., Terry Wood, M.D., or Hawaiian Eye Center. The assignment will remain in effect unless revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Patient Signature: _____ Date: _____

Emergency Contact: _____ Relationship: _____ Phone No: _____

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Past Ocular History: (Circle) **Cataracts** Glaucoma Lazy Eye Macular Degeneration Pterygium Retinal Detachment

Other: _____

Eye Surgeries (Date and Type): _____

List of Current **EYE** Medications:

1. _____ 2. _____ 3. _____

Other: _____

Past Medical History: (Circle all that apply)

Arthritis	Diabetes Type 1 or 2	Heme/Lymph Bleeding	Psychosocial
Asthma	Gastrointestinal	High Blood Pressure	Skin Problems
Cancer	Head and Neck Problems	Lungs/Respiratory	Thyroid
Cholesterol	Hear Problems	Neurological Problems	Urinary Problems

Previous Surgeries (Date and Type): _____

Systematic Medications (including aspirin and vitamins): Please bring in your list of medications to the office.

1._____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Other: _____

Family History: (Circle all that apply)

Diabetes	Stroke	Blindness	Macular Degeneration	Arthritis
Cataracts	TB	Cancer	Retinal Disease	Lazy Eye
Glaucoma	Kidney Disease	Heart Disease	High Blood Pressure	Other

Social History: (Circle all that apply)

Smoking: ☐ Yes ☐ No ☐ Never Smoked ☐ Former Smoker If yes, Frequency: ☐ Daily ☐ Some Days

Alcohol: ☐ Yes ☐ No If yes, Frequency: ☐ Daily ☐ Socially ☐ On Occasion

Recreational Drugs: ☐ Yes ☐ No If yes, Frequency: _____ Drug Used: _____

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Name: _____ Date of Birth: _____

Review of Systems: (Circle all that apply)

Eyes	**Respiratory**	**Blood/Lymph Nodes**	**Gastrointestinal**
Previous Surgery	Cough	Easy Bruising	Heartburn
Glaucoma	Congestion	Gum Bleeding Easily	Nausea/Vomiting
Cataracts	Wheezing	Prolonged Bleeding	Jaundice/Hepatitis
Macular Degeneration	Asthma	Heavy Aspirin Use	

Ears, Nose, and Throat	**Musculoskeletal**	**Skin**	**Genitourinary**
Hard of Hearing	Stiffness	Rash/Sores	Pain/Difficulty
Ringing of Ears	Arthritis	Lesions	Blood in Urine
Vertigo	Joint Pain/Swelling	Hives/Eczema	Kidney Stones

Cardiovascular	**Endocrine**	**Immunologic**	**Neurological**
Chest Pain	Increased Thirst	Hives	Seizures
Dizziness	Increased Hunger	Itching	Weakness/Paralysis
Fainting Spells	Increased Urination	Runny Nose	Numbness
Shortness of Breath	Increased Sweating	Sinus Pressure	Tremors
Irregular Heartbeat	Fingernail Changes		
Difficulty Lying Flat			

Psychiatric	**Constitutional**
Anxiety/Depression	Fatigue/Weakness
Mood Swings	Fever
Difficulty Sleeping	Weight Gain/Loss

Allergies: (Circle all that apply) or None

Penicillin Sulfa Aspirin Shellfish

If so, what is your reaction? _____

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Safety Reminders

- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Do not touch your eyes, nose, and mouth.
- Let our medical office know if you are sick.
- Please sanitize and wash your hands.
- Should you cancel or re-schedule your appointment, please call us 24 hours in advance otherwise, we will charge a $25 no show fee.

Once you have been dilated, the following may occur:

* Light Sensitivity
* Glare
* Blurred Vision
* Difficulty walking due to blurred vision
* Difficulty driving due to blurred vision

Wearing dark glasses after dilation helps to ease some of these challenges.

Please bring dark glasses with you to all your eye exams

I have been informed, my questions have been answered and I understand the vision and safety issues associated with dilation of the eyes. This notice covers the period from my first visit to my last visit.

_____ _____

Print Name Date

_____

Patient's Signature