Hawaii Vision Associates

Patient Registration Form

Name:_____
(Last) (First) (Middle)

Address:_____
(Street) (Apt#/Unit) (City) (State) (Zip code)

Phone:_____
(Home) (Day) (Mobile)

May we contact you via text messaging? Yes No

Birthdate:_____ Age:_____ SS#:_____
(Month / Day / Year)

Sex: M F Marital Status: S M D W Title: Mr. Mrs. Ms. Miss Dr.

E-mail address:_____

May we contact you via e-mail? Yes No

Patient Occupation:_____ Patient Employer:_____

Emergency Contact:_____
(Name) (Phone Number)

Referred by:_____ Friend Relative Internet Radio Newspaper TV

Please present your insurance card(s) and a picture ID for proper identification to the receptionist.

Insurance:_____ _____
(Vision Plan) (Medical Plan)

Subscriber:_____ _____ _____ _____
(Last, First Name) (Subscriber DOB) (Relationship) (SS# or ID#)

I have read and agree to the following:

I hereby authorize the staff of Robb T. Shibayama, OD, Inc. and Wendi N. Harada, OD, Inc. DBA Hawaii Vision Associates, to administer such treatments as reasonable or may be necessary in connection with the condition for which I or members of my family have sought care. To the extent necessary to determine the liability of payments and to obtain reimbursement, I hereby authorize Hawaii Vision Associates to apply for benefits on my behalf and to release portions of my records to any person, organization, or agency which is or may be liable for any portion of the office charge. I request that all payments from the agreed third party be made directly to Hawaii Vision Associates and I agree to assume full responsibility of payments pending any remaining balance that is not covered by the agreed third party. **I understand that payment is due at the time services are rendered unless other arrangements have been made.** I acknowledge that I reviewed the Hawaii Vision Associates Notice of Privacy Practices.

I understand that it is my responsibility to provide all insurance information.

Patient/Parent Signature:_____ Date:_____
(If patient is under 18, parent signature required)

Hawaii Vision Associates

Patient Information

Name:_____ Birthdate:_____ Age:_____
(Last) (First) (Middle)

Primary reason for visit: □ Eye Examination □ Contact Lens Examination □ Contact Lens Fitting/Evaluation

□ Vision Therapy □ Medical/Office Visit

	No	Yes
Vision Complaints		
Blurry Vision	□	□
Distorted Vision	□	□
Double Vision	□	□
Vision Loss:		
Central Vision	□	□
Side Vision	□	□
Spectacles/Glasses		
Vision:		
Adequate	□	□
Improvement needed	□	□
Contact Lenses		
Current brand:		
Would like to continue	□	□
Would like to change brands	□	□
Vision:		
Adequate	□	□
Improvement needed	□	□
Comfort:		
Adequate	□	□
Improvement needed	□	□
Hours of use:		
Days of use:		
Solution:		

	No	Yes
Ocular Complaints		
Abrasion	□	□
Allergies:		
Itchiness	□	□
Lid swelling	□	□
Discharge:		
Mucous	□	□
Tearing	□	□
Eye Pain	□	□
Flashes of light	□	□
Floaters in your vision	□	□
Black curtain	□	□
Redness	□	□
Lid Bump:		
Stye	□	□
Other:		□
Glare/Light Sensitivity	□	□
Headaches	□	□
Migraines	□	□
Other:		□

Ocular Complaints: Dryness

Have you experienced any of the following *during the last week*?

	Always	Most of the time	Half of the time	Sometimes	Never
Eyes that are sensitive to light?	□	□	□	□	□
Eyes that feel gritty?	□	□	□	□	□
Painful or sore eyes?	□	□	□	□	□
Blurred vision?	□	□	□	□	□
Poor vision?	□	□	□	□	□

***Within the last week,* have any of the following problems listed above limit your performance in the following activities?**

Reading?	□	□	□	□	□
Driving at night?	□	□	□	□	□
Working with a computer/phone?	□	□	□	□	□
Watching TV?	□	□	□	□	□

Have your eyes felt uncomfortable in any of the following situations *during the last week*?

Windy conditions?	□	□	□	□	□
Areas with low humidity (dry)?	□	□	□	□	□
Areas that are air conditioned?	□	□	□	□	□

Ocular History

Last Eye Exam:_____ By Dr._____
Have you ever had an eye surgery or injury? □ Yes □ No Describe:_____
Have you ever had an eye infection? □ Yes □ No Describe:_____
Interests/Hobbies?_____ Computer work? □ Yes □ No Hours per day:_____

Medical History

Primary physician:_____ Last Medical Exam:_____
Are you taking any medications (prescription, over the counter, and home remedies) and/or medicated eye drops? □ Yes □ No
Please List:_____
_____
Are you allergic to any medications and/or eye drops? □ Yes □ No Describe:_____
Have you ever had any major injuries, surgeries and/or hospitalizations? □ Yes □ No Describe:_____
_____
Are you Pregnant? □ No □ Yes: Trimester □ 1st □ 2nd □ 3rd Are you Nursing? □ Yes □ No

Social History

Do you currently drive? □ Yes □ No Are you interested in a DMV certificate? □ Yes □ No
Do you use tobacco products? □ Yes □ No If yes, type/amount/how often:_____
Do you drink alcohol? □ Yes □ No If yes, type/amount/how often:_____
Do you use any illegal drugs? □ Yes □ No If yes, type/amount/how often:_____

Please turn over, two-sided form.

Family History/Review of Systems

Please detail conditions that apply to only IMMEDIATE family members (mother/father/siblings).
Do you currently, or have you ever had any problems in the following areas:

	Self		Family	
	No	Yes	No	Yes
Allergies				
Describe:	☐	☐		
Cardiovascular				
Heart Attack/Stroke	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Other:		☐		
Constitutional				
Fever	☐	☐		
Weight Loss/Gain	☐	☐		
Endocrine				
Thyroid dysfunction	☐	☐	☐	☐
Diabetes				
Type 1 or 2	☐	☐	☐	☐
Blood Sugar:				
Hb A1C:				
Gout	☐	☐		
Other:		☐		
Gastrointestinal				
Diarrhea	☐	☐		
Constipation	☐	☐		
Bladder	☐	☐		
Kidney	☐	☐		
Other:		☐		
Genitourinary				
Prostate Disorder	☐	☐		
Menopause	☐	☐		
Other:		☐		
Ear, Nose, Throat				
Hearing Impaired	☐	☐		
Sinus Congestion	☐	☐		
Runny Nose	☐	☐		
Chronic Cough	☐	☐		
Other:		☐		
Hematologic/Lymphatic				
Anemia	☐	☐		
Other:		☐		

	Self		Family	
	No	Yes	No	Yes
Immunologic				
HIV Positive	☐	☐	☐	☐
AIDS	☐	☐	☐	☐
Sjogren' Syndrome	☐	☐	☐	☐
Other:		☐		
Integumentary-skin				
Eczema	☐	☐	☐	☐
Rosacea	☐	☐		
Other:		☐		
Musculoskeletal				
Arthritis	☐	☐	☐	☐
Muscle/Joint Pain	☐	☐		
Other:		☐		
Neurological				
Headaches	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Seizures	☐	☐		
Multiple Sclerosis	☐	☐		
Bell's Palsy	☐	☐		
Other:		☐		
Psychiatric				
ADD/ADHD	☐	☐	☐	☐
Asperger Syndrome/Autism	☐	☐	☐	☐
Depression	☐	☐		
Dementia	☐	☐		
Alzheimer's Disease	☐	☐		
Other:		☐		
Respiratory				
Asthma	☐	☐		
Bronchitis	☐	☐		
Emphysema	☐	☐		
Other:		☐		
Eyes				
Glaucoma	☐	☐	☐	☐
Cataract	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐
Other:		☐	☐	☐

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