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

Please check all that apply:

VISION COMPLAINTS

Blurry Vision □
Distorted Vision □
Double Vision □
Vision Loss:
Central Vision □
Side Vision □

SPECTACLES/GLASSES

Vision:
Adequate □
Improvement needed □

CONTACT LENS WEARERS ONLY

Current brand:_____
Would like to continue □
Would like to change brands □
Vision:
Adequate □
Improvement needed □
Comfort:
Adequate □
Improvement needed □
Hours of use per day:_____
How often do you replace them: _____
Solution:_____

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

	Always	Sometimes	Never
Have you experienced any of the following *during the last week*?			
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:_____
Have you ever had any major injuries, surgeries and/or hospitalizations? □ Yes □ No Describe:_____
_____
Are you Pregnant? □ Yes □ No: Trimester □ 1st □ 2nd □ 3rd Are you Nursing? □ Yes □ No

ARE YOU TAKING ANY MEDICATIONS? □ Yes □ No
If yes, please list:_____
_____

ARE YOU USING ANY EYE DROPS? □ Yes □ No
If yes, please list:_____
Are you allergic to any medications? □ Yes □ No
If yes, please list:_____

Please turn over, two-sided form.

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: _____

MEDICAL HISTORY/FAMILY HISTORY

Please check any conditions or illnesses you or your IMMEDIATE family members (mother/father/siblings) have NOW or EVER had:

	Self	Family
Allergies		
Describe:	☐	
Cardiovascular		
Heart Attack/Stroke	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Constitutional		
Weight Gain	☐	
Weight Loss	☐	
Endocrine		
Thyroid dysfunction	☐	☐
Diabetes		
Type 1 or 2	☐	☐
Blood Sugar:		
Hb A1C:		
Gout	☐	
Gastrointestinal		
Diarrhea	☐	
Constipation	☐	
Bladder	☐	
Kidney	☐	
Genitourinary		
Prostate Disorder	☐	
Menopause	☐	
Ear, Nose, Throat		
Hearing Impaired	☐	
Sinus Congestion	☐	
Runny Nose	☐	
Chronic Cough	☐	
Hematologic/Lymphatic		
Anemia	☐	

	Self	Family
Immunologic		
HIV Positive	☐	☐
AIDS	☐	☐
Sjogren' Syndrome	☐	☐
Integumentary-skin		
Eczema	☐	☐
Rosacea	☐	
Musculoskeletal		
Arthritis	☐	☐
Muscle/Joint Pain	☐	
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	
Multiple Sclerosis	☐	
Bell's Palsy	☐	
Psychiatric		
ADD/ADHD	☐	☐
Asperger Syndrome	☐	☐
Autism	☐	☐
Dementia	☐	
Alzheimer's Disease	☐	
Depression	☐	
Respiratory		
Asthma	☐	
Bronchitis	☐	
Emphysema	☐	
Eyes		
Glaucoma	☐	☐
Cataract	☐	☐
Macular Degeneration	☐	☐

Are you currently being treated for any other medical condition(s) not listed above? If yes, briefly describe: _____

_____

Patient/Parent Signature: _____ Date: _____ Dr. Signature: _____ Date: _____