VISION CARE CENTER OF Hawaii

94-050 Farrington Hwy, B1-1 Waipahu, HI 96797 (808) 677-1544

New Patient Information

Patient's Full Name ☐ **Miss** ☐ **Mrs.** ☐ **Mr.** _____

DOB ____ / ____ / _____ **Gender** ☐ **Male** ☐ **Female** **Last 4 of SSN**_____
Email_____ **Address** _____
Occupation_____ **City/State** _____ **Zip** _____
Employer _____**FT or PT** **Home Phone** _____
Grade/School _____ **Cell Phone** _____
Hobbies/Sports _____ **Work Phone** _____
Primary Care Physician_____ **Date Last Seen PCP** _____
PCP Phone:_____**Fax:**_____ **Other Medical Specialists**_____
Referred by_____ **How did you hear about us?**_____

Race ☐ **American/Alaskan Indian** ☐ **Asian** ☐ **Black or African American** ☐ **Hispanic**
☐ **Native/Part Hawaiian or Pacific Islander** ☐ **White**

Marital Status ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Legally Separated** ☐ **Widowed**

Vision Insurance _____ Member ID _____ Group # _____
Policy Holder's Name _____ DOB ____/____/____ Last 4 of SSN_____

Medical Insurance _____ Member ID _____ Group #_____
Policy Holder's Name _____ DOB ____/____/____ Last 4 of SSN _____

Patient History

Last Eye Exam: _____ **Reason for today's visit**:_____

Do you currently experience any of the following? (Please check all that apply)

☐ Blurred vision at distance ☐ Blurred vision at near ☐ Double vision ☐ Itchy eyes ☐ Dry Eyes ☐ Eye strain
☐ Eye Pain ☐ Floaters ☐ Flashes ☐ Red eyes ☐ Other _____

Do you currently wear contact lenses? ☐ Yes ☐ No **If yes, what brand/type do you wear?** _____

Do you want to have a contact lens exam today? ☐ Yes ☐ No

Are you interested in any eye surgeries/procedures? ☐ Yes ☐ No

History of Eye Conditions:	**You**	**Family Member(s): Please list family member(s)**
Blindness	☐ ☐	
Glaucoma	☐	☐
Cataract	☐	☐
Eye Turn/Lazy Eye	☐	☐
Color Vision Deficiency	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐
Retinal Disease	☐	☐
Eye Injury	☐	☐

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***Please complete both sides**

Review of Systems Please indicate below if you have or ever had problems with the following conditions:

Allergy/Immunologic	Ear, Nose, & Throat	Gastrointestinal	Integumentary	Psychiatric
__Lupus (SLE)	__Sinusitis	__Crohn's Disease	__Eczema	__Depression
__Rheumatoid Arthritis	__Upper Respiratory	__Colitis	__Rosacea	__Bi-polar
__Environmental Allergies	Infections	__Acid Reflux/Ulcer	__Psoriasis	__Schizophrenia
__Seasonal Allergies	__Hearing Loss			

Cardiovascular	Endocrine____	Respiratory	Muscle/Skeletal	Genitourinary
__High Blood Pressure	__Diabetes	__Asthma	__Arthritis	__Urinary Infection
__Heart Disease	__Year Diagnosed	__Emphysema	__Ankylosing Spondylitis	__Herpes
__Vascular Disease	A1c___%BS___	__Bronchitis	__Fibromyalgia	__HIV positive
__High Cholesterol	__Thyroid Dysfunction	__Tuberculosis		__Chlamydia

Hematologic/Lymphatic	Neurological	General Health
__Anemia	__Multiple Sclerosis	__Weight loss/gain
__Leukemia	__Epilepsy	__Fever
__Bleeding Disorder	__Tremors	__Fatigue
	__Headaches	__Trauma

Please list any other conditions not listed _____

Please list ALL your current **medications** (include eye drops, over the counter, and vitamins)_____

_____

_____

Please list any **allergic reactions** to medication or eye drops_____

_____

Please list all major **surgeries** (include eye surgery): _____

_____

Women: Are you currently pregnant and/or nursing? (if applicable) ☐ Yes ☐ No

Social/Tobacco/Alcohol History (Please check all that apply)

☐ Current smoker, __ per day ☐ Former Smoker ☐ Never a smoker

☐ Alcohol use, __ per day ☐ Recreational Drug use, __ per day

I request that payment of authorized Insurance benefits for any services furnished to me, be made on my behalf to ***Vision Care Center of Hawaii LLC.*** *I authorize any holder of medical information about me to release to my insurance company any information needed to determine these benefits or the benefits payable for related services. I understand that I am responsible for charges not paid by my insurance plan and I understand the Notice of Privacy Practices.*

Signature of Patient/Parent/Legal Guardian _____ Date _____

Doctor Reviewed _____

Written Financial Policy/ Prescription Release

Most people have a vision plan and medical insurance. While they seem similar, they are quite different regarding the services they cover, this form is to help you understand those differences.

- **Vision coverage** (VSP, EyeMed, etc.) is mainly designed to determine a prescription for glasses and does not cover complex medical conditions.
- **Medical coverage** (HMSA, UHA, UHC, HMAA, etc.) is filed when a medical condition is present such as diabetes, cataracts, dry eyes, floaters, etc. In this case, co-pays and deductibles for your medical insurance will apply.

We do our best to make sure you are aware of any out-of-pocket expenses associated with your visit. Unfortunately, in many cases, there is no way to know before the examination which type of insurance our office will file for you. Your insurance is not a substitute for payment. Insurance plans vary from plan to plan, and many companies have fixed allowances or percentages based on your contract with them, not with our office. It is your responsibility to pay for any co-payments, deductibles, coinsurance, or any other balances not paid for by your insurance company. We will assist you in receiving and filing for benefits as much as possible, but you are responsible for any services rendered.

Authorization to bill insurance on your behalf:

I understand the paragraph above, and I authorized Vision Care Center of Hawaii, LLC to file my insurance by the above guidelines. I am aware that I am responsible for any copayments or deductibles set in accordance with my insurance provider. I am also responsible for any treatment or testing that my insurance provider does not cover.

HIPAA Privacy Policy : By signing below you acknowledge that you have read the "Notice of Privacy Practices", provided to you with your check-in papers.

Retinal Screening: You will most likely receive a fundus photo screening today. This photo provides a picture of the inside of your eye / retina. It is extremely useful for diagnosing, educating patients, counseling, monitoring, and forecasting many ophthalmic conditions. The max out of pocket expense for this is $39.00, unless it is applied to a deductible by your insurance. It is not required but is highly recommended that you receive this service, especially as a new patient. By signing this form you agree to receive this service and pay any co-payments, deductibles, coinsurance, or any other balances not paid for by your insurance company.

Financial Agreement: By signing this statement, you agree to be financially responsible for all charges. Additionally, you authorize our office to utilize any personal/medical information needed to determine benefits payable for related services. This form will remain in effect until revoked by written notice. By signing the line below you consent to be contacted via text message and/or email for any balance due on your account.
TREATMENT PLAN ESTIMATES: As a courtesy to our patients, we will provide treatment plan estimates prior to treatment rendered so that you may have an estimate for your patient portion. Please note that treatment plans may change and that it is only an estimate of what your insurance will cover. You acknowledge that during treatment it may be necessary to change or add procedures, which may result in an adjustment to your patient responsibility. Estimates are based on the information provided by your insurance carrier and are not a guarantee of coverage for services rendered. Your estimated copay for services is due the day of treatment.

Missed or Cancelled Appointments: We require at least 48 hours notice for any appointment that needs to be rescheduled or cancelled. If this notice is not given to our office, we require a non-refundable $75 rescheduling fee to get back onto the schedule.

Signed Acknowledgement Form Following Prescription Release: Sign below to acknowledge that you were provided with a copy of your eyeglasses and/or contacts prescription immediately after completing any refractive eye examination.

Consent form For Electronic Delivery of Prescription
I would like my eyeglasses and/or contact lens prescription sent to me electronically via EMAIL.
CHECK Yes or No: Yes ☐ No ☐ *by answering with "No" you agree to get a paper copy only.

Patient Printed Name: _____

Patient Signature:_____ Date:_____