Hawaii Vision Associates

Windward (808) 247-8391
Pearlridge (808) 487-0789

Patient Registration Form

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

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

Phone:_____
(Home) (Work) (Mobile)

Birthdate:_____ Age_____ SS#_____

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

Email:_____

May we contact you via text messaging? Yes No

Occupation:_____Employer:_____

Emergency Contact:_____
(Name) (Phone #)

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:_____ _____ _____ _____
(plan) (subscriber name) (subscriber DOB) (relationship)

If you have **VSP** insurance provide subscriber's last 4 digits of their SS# _____

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 received a copy of Hawaii Vision Associates Notice of Privacy Practices.

Signature:_____Date:_____
(If patient is under 18, parent signature required)

Hawaii Vision Associates

Patient Information

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

Primary reason for today's visit: _____

Date of last eye exam:_____ By Dr. _____

Do you currently wear glasses? __Yes __No What type?_____
Do you currently wear contact lenses? __Yes __No What type?_____
Are you interested in contact lenses? __Yes __No What type?_____
Have you ever had eye surgery? __Yes __No When & why?_____
Have you had and eye injuries? __Yes __No When? _____
Have you ever had any eye infections? __Yes __No When? _____
Have you ever had your eyes dilated? __Yes __No When? _____
Any allergies to drops or solutions? __Yes __No What type?_____
Is there anything we should know about your eyes?_____
Hobbies?_____ Computer work? __Yes __No ____Hours per day

Medical Information

Primary physician:_____Last Medical Exam:_____
Are you taking any medications? __Yes __No What type?_____
_____
Are you allergic to any medications? __Yes __No What type?_____
Have you ever had any head injuries? __Yes __No Describe_____
Are you pregnant or nursing? __Yes __No Do you smoke? __Yes __No if yes, # of packs/day___

Personal and Family History

Please check any condition that applies to you or any **IMMEDIATE** family members (mom/dad/siblings):

Self	Family	
___	___	**High Blood Pressure**
___	___	**Diabetes Type 1 or 2**
___	___	**High Cholesterol**
___	___	**Arthritis**
___	___	**Thyroid Problems**
___	___	**Sinus Problems**

Self	Family	
___	___	**Asthma**
___	___	**Heart Disease**
___	___	**Lung Disease**
___	___	**Kidney Disease**
___	___	**Allergies**
___	___	**HIV/AIDS**

Self	Family	
___	___	**Glaucoma**
___	___	**Cataract**
___	___	**Macular Degen.**
___	___	**Lazy Eye**
___	___	**Strabismus**
___	___	**Eye Disease**

Please describe any other medical conditions:_____

Patient/Parent Signature:_____ **Date:**_____