Lāna`i Community Health Center | LEE & LEONG | MAUI OPTIX | HĀNA HEALTH

L a n a' i K a h u l u i P u k a l a n i H ā n a

Name (Last, First, MI) _____ (Mr. / Mrs. / Ms. / Dr.) Date of Birth _____
Primary Care Physician _____ Last Medical Exam Date_____
Previous Eye Doctor _____ Last Eye Exam Date_____
Employer_____ Occupation_____
Preferred Language _____Ethnicity (Optional)_____ □Male □Female

Contact Information (Please check preferred method of contact)

□Email_____ Address_____

□Cell _____ □ Work _____□

Home_____

Medical Insurance Medicare / Humana / HMSA / UHA / HMA / HMAA / VA / AlohaCare / Premier / UHC / Other_____

Vision Insurance VSP (subscriber's last 4 SSN_____)/ HMSA / UHA / Other _____

Emergency Contact / Policy Holder (If you are not the policy holder)
Name _____Phone _____Relation _____DOB _____

Notice of Privacy Practices

We do not share private information without your consent. A copy is posted and I am aware that a copy can be requested.

Dilated Eye Exam

I have been educated of the benefits and effects of a dilated exam, and (see clipboard for more information):

□**CHOOSE** to have dilated eye exam.

□**RESCHEDULE** the dilated eye exam.

□**REFUSE** the dilated eye exam. I take all responsibility for the consequences.

I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHERWISE ARRANGED.

Release of Identifying Health Information

I authorize *Maui Optix & Drs. Lee & Leong* to release or request health information under the following terms:

1. The information released or requested is limited to details of an eye exam, including tests.
2. Information would only be released or requested for the patient's health interests.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization.

I HAVE READ AND UNDERSTAND THIS FORM.
I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED ABOVE.

PATIENT SIGNATURE: _____ Date: _____ TURN OVER

(Guardian if under 18 years old)

We Share Aloha through Advanced and Accessible Eyecare

Medications (if you have a list please give to staff) ☐NONE

_____

_____

_____

Major injuries or surgeries ☐NONE

_____

Nursing or pregnant (if applicable) yes / no

General Health, Past or Present CIRCLE *conditions applicable*	**Other / Describe**
Eyes: blur / pain / itch / vision loss/ discharge / dry eyes / LASIK / inflammation / injury	
Past Ocular History: glaucoma / cataract / macular degeneration / surgery / retina	
Headache	
Constitution: developmental disorders / cancer / fatigue syndrome	
Ears, Nose, Throat: hearing loss / sinusitis / dry mouth / laryngitis	
Neuro: multiple sclerosis / epilepsy / cerebral palsy / tumor / stroke / migraine	
Psych: depression / attention deficit / anxiety disorder / bipolar disorder	
Cardio: hypertension / heart disease / vascular disease / congestive heart failure	
Respiratory: cigarette smoker / asthma / bronchitis / emphysema / chronic obstruction / sleep apnea	
Gastrointestinal: chron's / colitis / ulcer / acid reflux / celiac disease	
Genitourinary: kidney / prostate disease/cancer / STD / herpes / chlamydia	
Musc/Skel: osteoarthritis / arthritis / fibromyalgia / muscular dystrophy / ankylosing spondylitis / osteoporosis / gout	
Integumentary: eczema, psoriasis, rosacea / shingles	
Endocrine: thyroid dysfunction / hormonal dysfunction	
Diabetes: Type I / Type II	
Hem/Lymph: anemia / large blood loss / ucler / cholesterol	
Allergic/Immunologic: drug allergies / environmental allergies / rheumatoid arthritis / lupus / sjogren's syndrome	
Family History	CIRCLE *family applicable*
Cancer	Dad / Mom / Sister / Brother / Son / Daughter
Diabetes	Dad / Mom / Sister / Brother / Son / Daughter
High Blood Pressure / Stroke	Dad / Mom / Sister / Brother / Son / Daughter
Thyroid	Dad / Mom / Sister / Brother / Son / Daughter
Cataract	Dad / Mom / Sister / Brother / Son / Daughter
Macular degeneration	Dad / Mom / Sister / Brother / Son / Daughter
Glaucoma	Dad / Mom / Sister / Brother / Son / Daughter
Social History	
Do you or have you ever worn contacts? yes / no	If yes, brand?
Would you like to be evaluated for contacts? (additional fee may apply) yes / no	
Drink alcohol? yes / no	How often?
Do you smoke? yes - somedays / yes - everyday / former / no	
Hobbies:	

Who can we thank for referring you to our clinic? _____

PATIENT SIGNATURE: _____ Date: _____ TURN OVER

(Guardian if under 18 years old)