

ISLAND OPHTHALMOLOGY PARTNERS

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PLEASE PRESENT ALL VISION AND MAJOR MEDICAL INFORMATION TO RECEPTIONIST

PATIENT NAME _____ DATE _____

ADDRESS _____ HOME PHONE _____

CITY, STATE & ZIP _____ CELL PHONE _____

BIRTHDATE ____/____/____ SEX ☐ M ☐ F WORK PHONE _____

EMAIL ADDRESS _____

MARITAL STATUS ☐ M ☐ S ☐ D SS# ____/____/____

REFERRING PHYSICIAN: _____

RESPONSIBLE PARTY FOR INSURANCE : (IF OTHER THAN SELF)

NAME _____ PHONE () _____
LAST FIRST MIDDLE

ADDRESS _____ DOB: _____
STREET

CITY STATE ZIP CODE SSN _____

EMERGENCY CONTACT:

NAME: _____ PHONE: () _____

RELATIONSHIP TO PATIENT: _____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION TO INSURANCE COMPANY

INFORMATION REGARDING DILATING EYE DROP

I hereby authorize Island ophthalmology partners representative to release to my insurance company or representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Island ophthalmology. The assignment will remain in effect unless revoked by me in writing. A photocopy of this assignment will be considered as VALID as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I will be assessed a \$15.00 charge for each check returned due to insufficient funds. I further understand that a 1% finance charge (12% annually) maybe added to any balance over 90 days. In the event of default, I (we) promise to pay legal interest of the indebtedness, together with such collection costs and reasonable attorney fees as may be required to affect the collection of this note. I hereby authorize said assignee to release all information necessary to secure payment.

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. **Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.** Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. **I hereby authorize Island ophthalmology partners and/or such assistants as may be designated by him/her to administer dilating eye drops.**

The eye drops are necessary to diagnose my condition.

Signature

Date

Patient (or authorized person to sign for patient)

Date

PLEASE COMPLETE ALL PAGES OF THE FORM.

THANK YOU !

PATIENT MEDICAL HISTORY RECORD

Name: _____ Occupation: _____ Employer: _____

Primary Doctor: _____ Specialist Doctor(s): _____

Arthritis ☐ Yes ☐ No

Asthma ☐ Yes ☐ No

Cancer ☐ Yes ☐ No

Diabetes Mellitus ☐ Yes ☐ No

Heart disease ☐ Yes ☐ No

Hypercholesterolemia (high cholesterol) ☐ Yes ☐ No

Hypertensive disorder (Hypertension) ☐ Yes ☐ No

Seasonal allergy ☐ Yes ☐ No

Thyroid dysfunction ☐ Yes ☐ No

Rheumatoid arthritis ☐ Yes ☐ No

Are you being treated for any medical conditions? (e.g. Diabetes, High blood pressure, arthritis) ☐ Yes ☐ No

If yes: _____

Have you ever had any eye disease? (e.g. glaucoma, cataract, lazy eye, retinal detachment) ☐ Yes ☐ No

If yes, please provide date and reason: _____

Have you ever had any surgery? ☐ Yes ☐ No If yes: _____

Any hospitalizations? ☐ Yes ☐ No If yes, please provide date and reason: _____

Do you take any medications? ☐ Yes ☐ No If yes, please list all ACTIVE and CURRENT medications

(Attach a copy if needed)

Any food or drug allergies? ☐ Yes ☐ No If yes, please list allergies you may have

Family and Social History

Do ANY medical or eye diseases run in your family? (e.g. Diabetes, High blood pressure, Cancer, Glaucoma, Macular Degeneration) ☐ Yes ☐ No If yes, please explain: _____

Do you smoke? ☐ Yes ☐ No How many packs per day? _____ Drink Alcohol? ☐ Yes ☐ No

Comments _____

REVIEW OF SYSTEMS:

Do you currently have, or have you ever had, any of the following problems or conditions?

Chronic Fever, unexpected weight loss/gain, fatigue? ☐ Yes ☐ No _____

Ear/Nose/Throat Problems (e.g. Hearing Loss, Sinus problems, Sore throat) ☐ Yes ☐ No _____

Heart problems (e.g. chest pain, irregular heart beat) ☐ Yes ☐ No _____

Respiratory problems (e.g. shortness of breath, wheezing, coughing) ☐ Yes ☐ No _____

Urinary problems (e.g. pain or discomfort, blood in urine) ☐ Yes ☐ No _____

Skin problems (e.g. rashes, itching, dryness) ☐ Yes ☐ No _____

Musculoskeletal problems (e.g. muscle pain, joint pain, swollen joints) ☐ Yes ☐ No _____

Neurologic problems (e.g. numbness, weakness, headache, paralysis) ☐ Yes ☐ No _____

Psychiatric problems (e.g. Depression, anxiety) ☐ Yes ☐ No _____

SIGNATURE

DATE

Physician's Initials

CANCELLATION POLICY

Recently we have been experiencing a problem with what we call “no show” appointments. This means that patients are scheduling appointments for office visits or procedures and then simply not showing up for the appointment, without the courtesy of a call or notification prior to the visit.

We will try and remain flexible when this occurs, and ask you to do nothing more than discuss the situation with us.

Please note that this policy is effective as of **July 1, 2012**.

A. If you are unable to keep your appointment, YOU MUST NOTIFY THE OFFICE 24 HOURS PRIOR YOUR SCHEDULED APPOINTMENT.

B . If you are ill or have a last minute emergency, please contact the office immediately to reschedule.

C. There will be a CHARGE FOR NO SHOW APPOINTMENTS for which the patient will be responsible. The fee will be billed and must BE PAID PRIOR TO YOUR NEXT VISIT OR AT TIME OF YOUR NEW APPOINTMENT.

D. After the THIRD NO-SHOW , it will be the physician’s discretion as to whether a discharge letter will be sent out disengaging you from the practice. This means you will no longer be able to schedule appointments in our office.

E. The following fee will be applied for no show appointments:

\$50.00 CHARGE FOR NOT SHOWING UP FOR A VISIT. Please feel free to discuss any concerns you may have regarding this policy with our office manager, Hau’oli Winrow.

We thank you for your understanding and consideration for your fellow patients.

I understand and agree with the above.

SIGN _____ DATE _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR Island Ophthalmology Partners

I hereby acknowledge that I received from Island Ophthalmology Partners a copy of their Notice os Uses and Disclosures of Protected Health Information that details their Privacy Policy as required by the Health Information Portability and Accountability Act (“HIPAA”)

Print Name

Sign

Relationship to Patient (If other than Self)

Date