Welcome to Ohana Eye Care!

Patient Information

Name: _____
(First) (Middle) (Last) (Preferred / Nickname)

Address: _____
(#) (Street) (Apt / Ste #) (City) (State) (ZIP)

Date of Birth: _____ **Gender:** _____ **Ethnicity:** _____
(MM / DD / YYYY)

Employer: _____ **Occupation:** _____

Preferred Method of Contact *(please mark one)*: ☐ Call ☐ Text ☐ Email

Preferred Phone #: (_____) _____ - _____ ☐ Home ☐ Work ☐ Cell *(please mark one)*

Email Address: _____ **Referred By:** _____

Insurance Information (please complete for assistance with out of network reimbursement forms)

Primary Ins Co: _____
ID #: _____
Primary Insured:
First Name: _____
Last Name: _____
Date of Birth: _____
Last 4: _____
Relationship *(please mark one)*:
☐ Self ☐ Dependent Child
☐ Spouse ☐ Domestic Partner

Secondary Ins Co: _____
ID #: _____
Primary Insured:
First Name: _____
Last Name: _____
Date of Birth: _____
Last 4: _____
Relationship *(please mark one)*:
☐ Self ☐ Dependent Child
☐ Spouse ☐ Domestic Partner

I consent to allow Ohana Eye Care to provide care to me and agree to promptly pay for all applicable fees for products and services provided to me.

Signature of Patient or Legal Guardian: _____

Printed Name of Legal Guardian *(if applicable)*: _____

Today's Date: _____

Please Continue >>>

Ohana Eye Care: Patient History Form

Today's Date: _____ Patient Name: _____ Patient Date of Birth: _____

Reason for Today's Visit: _____

Other Current **Visual / Ocular Symptoms** (please mark all that apply):

Vision:	☐ Blurry	☐ Distorted	☐ Doubled
☐ Burning	☐ Itching	☐ Redness	☐ Tearing
☐ Eye Pain	☐ Headaches	☐ Floaters	☐ Flashes

Review of Systems (please mark all that apply and indicate the corresponding conditions):

- ☐ Constitutional: Cancer / Fever / Fatigue / _____
- ☐ Ear Nose Throat: Hearing Loss / Sinus / Dry Mouth / _____
- ☐ Neurological: MS / Seizures / Tumor / Migraine / Autism / _____
- ☐ Psychiatric: Depression / ADD / Anxiety / Bipolar / _____
- ☐ Cardiovascular: Hypertension / Stroke / Heart Disease / _____
- ☐ Respiratory: Smoker / Asthma / Emphysema / Sleep Apnea / _____
- ☐ Gastrointestinal: Crohn's / Ulcer / Celiac / _____
- ☐ Genitourinary: Kidney / Prostate / Pregnant / Nursing / STD / _____
- ☐ Musculoskeletal: Osteoarthritis / Fibromyalgia / Gout / _____
- ☐ Integumentary: Eczema / Rosacea / Psoriasis / Herpes / _____
- ☐ Endocrine: Diabetes / Thyroid / Hormonal / _____
- ☐ Hematologic Lymphatic: Anemia / Hypercholesteremia / _____
- ☐ Allergic Immune: Drug / Environment / RA / Lupus / Sjogren's / _____

Medications (please include name of medication, dosage, and frequency of use):

_____

Allergies (medications, environmental, latex, etc):

_____

Ocular History (please mark all that apply and indicate the date of onset):

- ☐ Glaucoma _____ ☐ Cataract _____ ☐ Amblyopia _____
- ☐ Macular Degeneration _____ ☐ Retinal Detachment _____ ☐ Dry Eye _____

Other: _____

Family Medical History (please mark all that apply and indicate the family member(s) with the condition):

- ☐ Cancer *(Type _____)*: _____ ☐ Hypertension: _____
- ☐ Diabetes *(Type _____)*: _____ ☐ Heart Disease: _____
- ☐ Thyroid (*please choose one Hyper / Hypo*): _____

Other: _____

Family Ocular History (please mark all that apply and indicate the family member(s) with the condition):

- ☐ Macular Degeneration: _____ ☐ Cornea Disease: _____
- ☐ Cataracts: _____ ☐ Retina Disease: _____
- ☐ Glaucoma: _____ ☐ Amblyopia *(Lazy / Crossed)*: _____

Other: _____

Contact Lens History:

Type: _____ Brand: _____ Replacement Cycle: _____ Overnight Wear: _____

Solution: _____ Problems: _____

Eyeglass History:

Age: _____ Used for: _____ Problems: _____

Signature of Patient or Legal Representative: _____ **Date:** _____

Name of Legal Representative *(please print)*: _____ **Relationship:** _____

Please Continue >>>

Ohana Eye Care: Privacy Acknowledgment and Disclosure Authorization

Acknowledgment of HIPAA Policies *(Effective Date 12/26/2013)*:

_____ *(initials)* I acknowledge that I have read and / or received a copy of the Notice of Privacy Practices *(Effective Date 12/26/2013)*.

Authorization to Discuss Patient Information *(please initial selections and complete corresponding blanks)*:

_____ *(initials)* I authorize the disclosure of the specified information, described below, only to the parties that are also described below until *(please mark one of the following time frames)*:

- ☐ expiration date or event _____
- ☐ no expiration date or event

Patient whose specified information will be disclosed:

Name: _____ Date of Birth: _____

Description of the specified information to be disclosed *(please mark all that apply)*:

☐ Appointment Dates / Times	☐ Test Results	☐ Insurance Benefits
☐ Diagnoses	☐ Medications	☐ Itemized Invoices
☐ Care Plans	☐ Summary of Records	☐ Other: _____

_____ *(initials)* **I would like the following health history information to remain confidential** *(please mark all that apply)*:

☐ Mental Health ☐ HIV Status ☐ Alcohol / Recreational Drug Information

Parties to which specified information will be disclosed:

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
_____	_____
Phone #: _____	Phone #: _____

I understand that (a) I may inspect the information to be disclosed, (b) I may revoke this authorization in writing, (c) this authorization gives Ohana Eye Care the right to discuss my information with the parties listed above, (d) information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA, and (e) I may refuse to sign this authorization and you will not condition treatment on my providing this authorization.

Signature of Patient / Legal Representative: _____

Printed Name of Legal Representative: _____

Relationship of Legal Representative: _____ **Today's Date:** _____