Welcome to our office! Dr. Iida and staff thank you for entrusting us with your visual care needs. Your satisfaction and eye health are very important to us. If you have any questions, please don't hesitate to ask for assistance.

Mahalo!

## Patient Information

**Today's Date** ____________

Last ______________________________

First ________________________ MI _____

Date of Birth ______________ Age _______

Gender M F Email Address ____________

Street _____________________________

City____________State ___ Zip Code _______

Cell Phone __________________________

Home Phone _________________________

Patient's SSN _______________________

Employer (or School) __________________

Occupation (or Grade) _________________

Hobby/Recreation ____________________

Marital status _______________________

Spouse (or Parent's Name) ______________

Spouse (or Parent's Work) ______________

Emergency contact:

Name/Relationship ___________________

Phone ___________ Email _____________

What is the major purpose of this visit?

__________________________________

Any problems with your current contact lenses or glasses? ____________________________

__________________________________

***VERY IMPORTANT! NEW PATIENTS ONLY:***

Who may we thank for referring you to our office?

Name of friend or relative ______________

If not referred, how did you choose our office?

- ☐ Another Dr.
- ☐ Insurance List
- ☐ Saw Sign/Building
- ☐ Newspaper/Radio/TV
- ☐ Yelp
- ☐ Web Page: Which Web Site? __________
- ☐ Other ______________________________

## Insurance Information

Vision Insurance _____________________

Subscriber Name _____________________

Subscriber SSN_______________________

Subscriber Birth Date__________________

Primary Medical Insurance______________

Subscriber Name _____________________

Subscriber SSN_______________________

Subscriber Birth Date__________________

Do you participate in a flex spending account?

☐ Yes ☐ No

How will you settle your account today?

☐ Cash ☐ Check ☐ Credit Card

## Lifestyle Questions

**Do you……(check box if your answer is yes)**

- ☐..work long hours at a computer?___ hrs/day
- ☐..think you might benefit from thinner, lighter lenses?
- ☐..have interest in a "test drive" of the latest contact lens designs
- ☐..spend time outdoors? How much? ___ Hrs/week
- ☐..have prescription sun wear or nonprescription sun wear?
- ☐..prefer not to wear your glasses at times?
- ☐..want information on Laser Vision Correction surgery?
- ☐..have more than 1 pair of current Rx eyewear?
- ☐..have children?
- ☐..have family members in need of eyecare?
- ☐..have a history of eye surgery? Type ______________

**Have you ever experienced, been diagnosed or treated for any of the following?**

| | |
|---|---|
| ☐ Blurry Vision | ☐ Burning |
| ☐ Cataracts | ☐ Corneal Abrasions |
| ☐ Crossed eye/Eye turn | ☐ Double Vision |
| ☐ Eye Infections | ☐ Eye Injury |
| ☐ Flash of light | ☐ Floaters/Spots |
| ☐ Glaucoma | ☐ Grittiness |
| ☐ Headaches | ☐ Iritis/Uveitis |
| ☐ Itchiness | ☐ Lazy Eye |
| ☐ Macular Degeneration | ☐ Occasional dryness |
| ☐ Retinal Detachment | ☐ Sunlight Sensitivity |
| ☐ Tearing | ☐ Trouble seeing at night |
| ☐ Uncomfortable glasses | ☐ Other ____________ |

**The information in this confidential case history form is critical to the evaluation of your vision and health.**

## Patient Medical History

Name of Family Physician ______________________
City ____________________________________________
Date of Last Physical Check-up _______________________

**CURRENT MEDICATIONS (Rx or Over the Counter)**
(List name of medications including eye drops, vitamins, & birth control pills)________________________________
_______________________________________________

Allergies to medications? ☐ Yes ☐ No
If so, what medications? _________________________
_______________________________________________

Have you had any surgeries? ☐ Yes ☐ No
Type of surgery ____________________________________
Do you use cigarettes/tobacco, alcohol, or other substances? ☐ Yes ☐ No

| **Have you ever been diagnosed or treated for the following health problems?** | **Yes** | **No** |
|---|---|---|
| Arthritis | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Atrial fibrillation | ☐ | ☐ |
| Cerebrovascular accident | ☐ | ☐ |
| Chronic obstructive lung disease | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| End-stage renal disease | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| GERD | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| High cholesterol | ☐ | ☐ |
| HIV | ☐ | ☐ |
| Hyperthyroidism | ☐ | ☐ |
| Hypothyroidism | ☐ | ☐ |
| Inflammatory disease of liver | ☐ | ☐ |
| Leukemia | ☐ | ☐ |
| Malignant lymphoma | ☐ | ☐ |
| Malignant tumor of breast | ☐ | ☐ |
| Malignant tumor of colon | ☐ | ☐ |
| Malignant tumor of lung | ☐ | ☐ |
| Malignant tumor of prostate | ☐ | ☐ |
| Radiation therapy treatment | ☐ | ☐ |
| Transplantation of bone marrow | ☐ | ☐ |

Other ___________________________________________

## Patient Eye History

Date of Last Eye Exam _____________Dilated? ________
By Whom? _______________________________________

Have you ever tried contact lenses? ☐ Yes ☐ No
Do you currently wear contact lenses? ☐ Yes ☐ No
What kind? ______________________________________
Is it for astigmatism, multifocal, monovision? ☐ Yes ☐ No

Are you satisfied with the vision and comfort of your contact lenses? ☐ Yes ☐ No
How many hours do you wear your contact lenses? ______
How often do you replace your contact lenses?__________
Do you sleep in your contact lenses?
☐ Yes ☐ No

If you wear bifocals, do the lines or head tilting bother you?
☐ Yes ☐ No

## Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:

Relationship
(Mother's or Father's side)

| | | | |
|---|---|---|---|
| Blindness | ☐ | Cancer | ☐ |
| Cataracts | ☐ | Diabetes | ☐ |
| Glaucoma | ☐ | Heart Disease | ☐ |
| High blood pressure | ☐ | Macular Degeneration | ☐ |
| Stroke | ☐ | Thyroid | ☐ |

I authorize Makana Vision to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to a third party payer and/or health practitioner.

I understand that all applicable copayments and deductibles are due at the time of service.I authorize and request my insurance company to remit payment directly to Makana Vision otherwise payable to me. I understand that my eye care insurance carrier(s) may pay less than the actual bill for services and I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature _______________________ Date ______________