ALOHA VISION CONSULTANTS

Carlton Yuen, MD ~ Jason Tokunaga, MD ~ Gilbert Yamamoto, MD
Kelly Ann Koide, OD ~ Kelly Moore, OD ~ Kiira Harrison, OD ~ Joanne Soriano-Rigdon, OD

Last Name: _____

First Name:_____ **Middle Initial:**_____ **Nickname:** _____

Address: _____**Apt#:**_____**Zip code:**_____

Billing Address (If different): _____ **Apt#:**_____**Zip code:**_____

Date of Birth:_____ **Gender (Circle One):** MALE / FEMALE

Marital Status (Circle One): single/married/divorced/widowed/other **Social Security Number:**_____

Primary Phone Number:_____ **Cell Phone Number:**_____

Email Address:_____ **Work Phone Number:**_____

PRIMARY INSURANCE

_____ _____ _____
Insurance Company *Subscriber Name* *Subscriber Date of Birth / Relationship*

SECONDARY INSURANCE

_____ _____ _____
Insurance Company *Subscriber Name* *Subscriber Date of Birth / Relationship*

Referring Doctor: _____ **Primary Care Physician:** _____

Emergency Contact: _____ **Emergency Contact Phone #:** _____

CONSENT TO RELEASE: Authorization is hereby given to Aloha Vision Consultants to disclose and furnish any and all health care information including medical records, reports, x-rays, diagnostic test results, bills, and payment records with respect to medical treatment or qualified healthcare operations provided to:

a) Any health insurance plan/company that provides coverage for me for the purpose of payment of charges.
b) Any insurance company that provides liability insurance coverage for Aloha Vision Consultants for the purpose of evaluating treatment rendered to me.
c) To leave messages regarding my appointments of health information on my answering machine/voicemail.

I give permission to speak to the following regarding my medical information and treatment:

_____ _____ _____ _____
Name Relationship Name Relationship

This authorization shall cover the period of time from my first visit to my last. I understand that I can revoke this authorization at any time. This authorization shall end 2 years from the date of my last visit. I release Drs. Carlton Yuen & Jason Tokunaga from all legal responsibility that may arise from this authorization.

PLEASE READ: We ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to Aloha Vision Consultants. I understand that my insurance will be billed as my primary insurance. You may be required to fill out a questionnaire for billing multiple insurance companies. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. **A notice of Aloha Vision Consultant Notice of Privacy Practices has been made available to me. I understand my rights regarding my medical records.**

_____ _____
Patient Signature **Date**

Patient Name _____
What is the reason for your visit today? _____

When was your last Vision Exam? _____ **When did you last see your Primary Care Physician?** _____

Personal Medical History (please check)

☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Cataract
☐ Yes ☐ No Macular Degen
☐ Yes ☐ No Retina Detachment
☐ Yes ☐ No Flu Shot
☐ Yes ☐ No Pneumonia Vaccine
☐ Yes ☐ No AIDS/HIV
☐ Yes ☐ No Allergies

☐ Yes ☐ No Anxiety
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Asthma
☐ Yes ☐ No Cancer
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Heart Disease
☐ Yes ☐ No High Blood Pressure (Hypertension)

☐ Yes ☐ No High Cholesterol
☐ Yes ☐ No Hyperthyroidism
☐ Yes ☐ No Hypothyroidism
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Pregnant/Nursing
☐ Yes ☐ No Other:
_____

Surgical History: (please include surgeon's name)

☐ None
1) _____ 2) _____
3) _____ 4) _____

Medications:

☐ None
1) _____ 6) _____
2) _____ 7) _____
3) _____ 8) _____
4) _____ 9) _____
5) _____ 10) _____

Allergies:

☐ None
1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Family History:

☐ Yes ☐ No Noncontributory
☐ Yes ☐ No Macular Degeneration
☐ Yes ☐ No Blindness
☐ Yes ☐ No Cataract
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Retinal Detachment
☐ Yes ☐ No Amblyopia (lazy eye)
☐ Yes ☐ No Arthritis or Rheumatism
☐ Yes ☐ No Cancer

☐ Yes ☐ No Diabetes
☐ Yes ☐ No Headaches/Migraines
☐ Yes ☐ No Heart Disease
☐ Yes ☐ No Hypertension (blood pressure)
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Thyroid Disease
☐ Yes ☐ No Stroke
☐ Yes ☐ No Uveitis
☐ Yes ☐ No Adopted/Unknown

Social History:

Do you wear Glasses?: ☐ Yes ☐ No
Do you wear Contacts?: ☐ Yes ☐ No If Yes, What Brand_____
Smoking/Tobacco: ☐ Never ☐ Former ☐ Current Every Day Smoker ☐ Current Some Day Smoker
Alcohol: ☐ None ☐ Occasional ☐ 1-2 Drinks/day ☐ 3-4 Drinks/day
Illegal Drugs: ☐ None ☐ Cocaine ☐ Heroin ☐ Amphetamines ☐Marijuana ☐Other_____
Occupation: _____ Driving: ☐ YES ☐ NO
Living Conditions: ☐ Alone ☐ Nursing Home ☐ Retirement Center ☐ With Family

Patient Name _____

Review of Systems

Allergy/Immunology
☐ Yes ☐ No Autoimmune Disease
☐ Yes ☐ No Seasonal Allergies

Cardiovascular
☐ Yes ☐ No Chest Pain
☐ Yes ☐ No Shortness of Breath
☐ Yes ☐ No Swelling of the Feet
☐ Yes ☐ No Shortness of Breath when Laying Flat
☐ Yes ☐ No Racing Pulse
☐ Yes ☐ No Irregular Heart Beat
☐ Yes ☐ No Blood Pressure Stable
☐ Yes ☐ No Blood Pressure uncontrolled

Constitutional
☐ Yes ☐ No Fever
☐ Yes ☐ No Weight Loss
☐ Yes ☐ No Fatigue
☐ Yes ☐ No Loss of Appetite
☐ Yes ☐ No Chills
☐ Yes ☐ No Unexplained Weight Loss
☐ Yes ☐ No Night Sweats
☐ Yes ☐ No Feels Sick
☐ Yes ☐ No Poor Appetite

Endocrine
☐ Yes ☐ No Excess Thirst
☐ Yes ☐ No Excessive Urination
☐ Yes ☐ No Heat Intolerance
☐ Yes ☐ No Cold Intolerance
☐ Yes ☐ No Hair Loss
☐ Yes ☐ No Dry Skin
☐ Yes ☐ No Blood Sugars Poorly Controlled
☐ Yes ☐ No Blood Sugars Stable

Gastrointestinal
☐ Yes ☐ No Abdominal Pain
☐ Yes ☐ No Nausea
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Bloody Stools
☐ Yes ☐ No Stomach Ulcers
☐ Yes ☐ No Constipation
☐ Yes ☐ No Trouble Swallowing
☐ Yes ☐ No Jaundice or Yellow Skin

Genitourinary
☐ Yes ☐ No Pain/Burning on Urination
☐ Yes ☐ No Blood in Urine
☐ Yes ☐ No Bladder Trouble
☐ Yes ☐ No Dialysis
☐ Yes ☐ No Genital Sores or Ulcers
☐ Yes ☐ No Kidney Failure
☐ Yes ☐ No Kidney Problems
☐ Yes ☐ No Prostatitis
☐ Yes ☐ No Testicular Pain
☐ Yes ☐ No Urinary Discharge

Hematology/Oncology
☐ Yes ☐ No Easy Bruising
☐ Yes ☐ No Prolonged Bleeding

HENT
☐ Yes ☐ No Hearing Loss
☐ Yes ☐ No Sore Throat
☐ Yes ☐ No Runny Nose
☐ Yes ☐ No Dry Mouth
☐ Yes ☐ No Jaw Claudication
☐ Yes ☐ No Ear Ache

Integumentary
☐ Yes ☐ No Rash
☐ Yes ☐ No Change in Mole
☐ Yes ☐ No Skin Sores
☐ Yes ☐ No Skin Cancer

Musculoskeletal
☐ Yes ☐ No Muscle Aches
☐ Yes ☐ No Joint Pain
☐ Yes ☐ No Difficulty Laying Flat
☐ Yes ☐ No Back Pain while sleeping or Awakening

Neurologic
☐ Yes ☐ No Weakness
☐ Yes ☐ No Headaches
☐ Yes ☐ No Scalp Tenderness
☐ Yes ☐ No Dizziness
☐ Yes ☐ No Paralysis of Extremities
☐ Yes ☐ No Tremor
☐ Yes ☐ No Stroke
☐ Yes ☐ No Numbness
☐ Yes ☐ No Seizures/Convulsions
☐ Yes ☐ No Fainting

Psychiatric
☐ Yes ☐ No ADHD
☐ Yes ☐ No Bipolar Disorder
☐ Yes ☐ No Depression

Respiratory
☐ Yes ☐ No Wheezing
☐ Yes ☐ No Cough
☐ Yes ☐ No Coughing up Blood
☐ Yes ☐ No Severe or Frequent Colds
☐ Yes ☐ No Difficulty Breathing

ALOHA VISION CONSULTANTS

Consent to Obtain Patient Medication History

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to insure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

_____ _____

Patient Name (Print) Name and Relationship of Legal Representative

_____ _____

Patient Signature (or Legal Representative) Date