Patient Form

General Information

First, Middle, Last, Preferred Name:

Street Address:

City, State, Zip:

Phone 1, Type:

Phone 2, Type:

Email:

Preferred Contact Method: ☐ Phone ☐ Text ☐ Email

Date of Birth: Gender:

Occupation/Employer:

Marital Status:

Language, Race, Ethnicity:

Emergency Contact Name and Number:

Authorized person to dispense materials or release information to (ex. glasses, contacts, prescriptions

Insurance Information

Vision Insurance:

Member Name:

Member ID or Social Security # (Required):

Member Date of Birth:

Primary Health Insurance: ☐ HMO ☐ PPO

Responsible Party:

Secondary Health Insurance: ☐ HMO ☐ PPO

Responsible Party:

Eye History/Medical History

Date of Last Eye Exam: Currently Wear Glasses? Currently Wear Contacts?

Height Weight

Current Medications, Supplements, or Vitamins:

Medication Allergies:

Have you had any surgeries or procedures done?

Do you have any allergies to foods, fabrics, or seasonal?

Who can we thank for referring you?

Patient Form

Eye History

Have you or a family member experienced or been treated for any of the following? Check all that apply.

Cataract ☐ Yes ☐ No ☐ Family
Glaucoma ☐ Yes ☐ No ☐ Family
Cross Eyed ☐ Yes ☐ No ☐ Family
LASIK or RK ☐ Yes ☐ No ☐ Family
Lazy Eye ☐ Yes ☐ No ☐ Family
Macular Degeneration ☐ Yes ☐ No ☐ Family
Retinal Detachment ☐ Yes ☐ No ☐ Family

Are you currently experiencing or have experienced

Blurry Vision ☐
Burning ☐
Discharge ☐
Double Vision ☐
Dryness ☐
Excess Tearing/Watering ☐
Eye Infection ☐
Eye Pain or Soreness ☐
Floaters or Spots ☐
Halos ☐
Itching ☐
Light Flashes ☐
Light Sensitivity ☐
Redness ☐
Sandy or Gritty Feeling ☐

Medical History

Have you or a family member experienced or been treated for any of the following? Check all that apply.

AIDS/HIV ☐ Yes ☐ No ☐ Family
Allergies ☐ Yes ☐ No ☐ Family
Arthritis ☐ Yes ☐ No ☐ Family
Asthma ☐ Yes ☐ No ☐ Family
Blood/Lymph Disorder ☐ Yes ☐ No ☐ Family
Cancer ☐ Yes ☐ No ☐ Family
Diabetes ☐ Yes ☐ No ☐ Family
Ear, Nose, Throat Condition ☐ Yes ☐ No ☐ Family
Gastrointestinal Condition ☐ Yes ☐ No ☐ Family
Heart Disease ☐ Yes ☐ No ☐ Family
High Blood Pressure ☐ Yes ☐ No ☐ Family
High Cholesterol ☐ Yes ☐ No ☐ Family
Kidney Disease ☐ Yes ☐ No ☐ Family
Lupus ☐ Yes ☐ No ☐ Family
Neurological Conditions ☐ Yes ☐ No ☐ Family
Psychiatric Disorder ☐ Yes ☐ No ☐ Family
Seizures ☐ Yes ☐ No ☐ Family
Skin Conditions ☐ Yes ☐ No ☐ Family
Stroke ☐ Yes ☐ No ☐ Family
Thyroid Dysfunction ☐ Yes ☐ No ☐ Family
Do you smoke? ☐ Yes ☐ No ☐ In the past
If yes, how often: _____
Do you drink alcohol? ☐ Yes ☐ No ☐ In the past
If yes, how often: _____

Certification/Authorization

By signing below I state that I am aware confirmation is required to keep my appointment, if not confirmed 24 hours before I am scheduled I authorize the office to cancel my appointment and apply a $50 fee to my account. I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits directly to Roger A. Hayashi, OD on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health coverage (as indicated in item 9 of the HFCA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Patient/Parent of Minor _____ Date _____ Doctor Reviewed _____