EYES PLUS INC
Family Vision Care

Patient Information

Welcome to Eyes Plus Inc! Dr. Makini 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!

Date: ____/____/____ Full Name: _____

SSN: _____-____-_____ DOB: ____/____/____ Home Ph: _____Wk Ph: _____

Cell: _____Email Address: _____/ Gender: ___M/ ___F

Best phone contact to reach you is: ___Home/ ___Work/ ___Cell/ _____Other

Address: _____City: _____ Zip: _____

Current Status: ____Minor/ ____Single/ ____Married/ ____Separated/ ____Divorced/ ____Widowed/ ____Student

Name of Employer (if a minor, use parent or guardian's info) _____

Occupation: _____ Business address: _____City: _____Zip:_____

Spouse's Name: _____ Ph: _____

Employer: _____Occupation: _____ Wk Ph: _____

Person to contact in case of emergency: _____

Relationship to patient: _____ Ph:_____

How did you hear of us? ___Our Website/ ___Other Website/ ___Walk-by/___Referral/ _____Other

Insurance/Responsible Party:

Name of person responsible for this account: _____

Relationship to patient: _____Phone: _____

Address: _____City: _____ Zip: _____

Name of Employer: _____ Work Ph:_____

Insurance Carrier: _____ Name of Insured: _____

Secondary Insurance Carrier Info: _____

Health History:

Name of previous EYE Doctor: _____ Last Exam Date: _____

Does anyone in your FAMILY have a history of the following illnesses? ___Diabetes/ ___Blindness/ ___Cataracts/

High Blood Pressure/ ___Thyroid/ ___Lazy Eye/ ___Glaucoma/ ___Heart Disease/ ___HIV/ ___TB/ ___Hepatitis/

___Other - please list: _____

Do you smoke? ___Yes/ ___No/ Are you pregnant? ___Yes/ ___No/ Do you have headaches? ___Yes/ ___No

List any ALLERGIES you might have (including medication allergies): _____

List all MEDICATIONS you are currently taking: _____

_____

Do YOU have a history of the following EYE conditions? ___Had Surgery/ ___Eye Infection/ ___Sensitivity to light/

___ See Spots or Floaters/ ___Flashing lights/ ___Blurred Far Vision/ ___Blurred Near Vision/ ___Dizziness/

___Nausea/ ___Itchy Eyes/ ___Burning Sensation/ ___Temporary loss of total eyesight in one or both eyes/

Do YOU currently wear Glasses? ___Yes/ ___No/ **If YES**, when?__ALL the time/___READING only/___DRIVING only

Do YOU currently wear Contacts? ___Yes/ ___No/ **If YES**, what BRAND and POWER are they? _____

What BRAND of SOLUTION(s) are you currently using? _____

If NO, did you ever wear contacts before? ___Yes/ ___No/ Are you interested in wearing contacts? ___Yes/ ___No

Any other information, inquires, requests or special needs I have: _____

_____

Authorization

I certify that the information given above is to the best of my knowledge. I understand that giving incorrect information could be hazardous to my health. I authorize Dr. Henry Makini of Eyes Plus, Inc. 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 authorize and request my insurance company to remit payment directly to Dr. Henry Makini of Eyes Plus, Inc. otherwise payable to me. I understand that my eye care insurance carrier 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. I understand that Dr. Makini and staff will be contacting me for any necessary follow-up appointments and/or annual visits in an effort to maintain continued quality of care of my visual health needs.

Patient Signature: _____ **Date:** _____

Responsible Party Signature (if different from above)**:** _____ **Date:**_____