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!

Today's Date: _____/_____/_____ Full Name: _____

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

Cell: _____ Email Address: _____/ Birth Sex: ___ M/ ___F

Best phone contact to reach you: ___Home/ ___Work/ ___Cell/ _____ Other

Address:_____ State:_____ City:_____ Zip:_____

Current Status: ___Minor/ ___Single/ ___Married/ ___Separated/ ___Divorced/ ___Widowed/ ___Student

Employer: _____ Ph: _____ Occupation: _____

Employer Address: _____ State: _____ City: _____ Zip: _____

Spouse's Name: _____ Ph: _____

Spouse's Employer: _____ Occupation: _____ Ph: _____

How did you hear of us? __Our Website/ __Walk-by/ __Referral/ __Insurance/ __Other: _____

Emergency Contact:

Name of Person to contact in case of emergency: _____

Relationship: _____ Ph:_____ Email:_____

Insurance/Subscriber Info: ***List ALL Vision+Medical Insurances** (if insured/subscriber is yourself, please write "**self**")

***Primary Insurance**: _____ Insured/Subscriber: _____

Relationship to patient: _____ DOB: _____/_____/_____ Ph: _____

Address: _____ State: _____ City: _____ Zip: _____

Insured Employer: _____ Ph: _____

***Secondary Insurance**: _____ Insured/Subscriber: _____

Relationship to patient: _____ DOB: _____/_____/_____ Ph: _____

Address: _____ State: _____ City: _____ Zip: _____

Insured Employer: _____ Ph: _____

Tertiary Insurance: _____ Insured Subscriber: _____

Relationship to patient: _____ DOB: _____/_____/_____ Ph: _____

Primary Care Physician:

Name of PRIMARY CARE Doctor: _____ Last Exam Date: _____

Facility Name: _____ Ph: _____

Health Information:

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

Anyone in your FAMILY have a history of the following? __Diabetes/ __Blindness/ __Cataracts/ __Thyroid/ __Lazy Eye/ __HIV/ __TB/ __High Blood Pressure/ __Glaucoma/ __Heart Disease/ __Hepatitis/ __Rheumatoid Arthritis/ __ Macular Degeneration/ __Other: _____

Do YOU have a history of the following? __Diabetes// __Cataracts/ __Thyroid/ __HIV/ __TB/ __High Blood Pressure/ __Heart Disease/ __Hepatitis/ __Rheumatoid Arthritis/ __Other:_____

Do YOU have a history of the following EYE conditions? __Surgery/ __Blindness/ __Eye Infection/ __Lazy Eye/ __Sensitivity to light/ __Glaucoma/ __ See Spots or Floaters/ __Flashing lights/ __ Macular Degeneration/__Blurred Far Vision/ __Blurred Near Vision/ __Dizziness/ __Nausea/ __Itchy Eyes/ __Burning Sensation/ __Temporary loss of total eyesight in one or both eyes/ __Headaches/ __Other:_____

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

_____

Do YOU take any of the following MEDICATION?: __Hydroxychloroquine/Plaquenil/ __Elmiron/ __Topiramate/ __Tamoxifen/ __Phosphodiesterase inhibitors (PDE-5)/ __Fingolimod/ __Ethambutol/ __Warfarin/Blood Thinners/ __Bisphosphonates/ __Isotretinoin/ __tamsulosin/ __Amiodarone/ __Atrovastatin/ __Amlodipine/ __Lisinopril/ __Atorvastatin/ __Insulin/ _Losartan/ __Metformin/ __Other: _____

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

Current Wear/Correction:

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? _____

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, requests or special needs: _____

_____

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 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. Makini of Eyes Plus, Inc. 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.

I understand that Eyes Plus Inc. will be contacting me for any necessary follow-up appointments and/or annual visits in an effort to maintain continued quality of care for my visual health needs.

Patient Name _____ **Date** _____

Patient or Parent/Guardian Signature (if under age 18) _____

Parent/Guardian Name (if signed above) _____ **Relationship** _____

Revised 01/2022