HAWAII EYE INSTITUTE

GREGORY W. SCHMIDT, M.D.
CORNEA, CATARACT, REFRACTIVE SURGERY
AND COMPREHENSIE OPHTHALMOLOGY

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I._____

Date of Birth:_____ Sex: ☐ Female ☐ Male

Social Security #:_____ Ethnicity: _____

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

Home Phone: _____ Work Phone:_____

Cell Phone:_____ Email:_____

Employer:_____ Occupation:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Partner

Referred By:_____

INSURANCE INFORMATION

Primary Insurance: _____ Policy Number: _____ Group:_____
Subscriber's Name: _____ Subscriber's DOB: _____
Subscriber's Sex: M☐ F☐ Relationship to Subscriber: _____
Employer: _____ Employment Status: F/T☐ P/T☐ Retired☐

Secondary Insurance: _____ Policy Number: _____ Group:_____
Subscriber's Name: _____ Subscriber's DOB: _____
Subscriber's Sex: M☐ F☐ Relationship to Subscriber: _____
Employer: _____ Employment Status: F/T☐ P/T☐ Retired☐

Tertiary Insurance: _____ Policy Number: _____ Group:_____
Subscriber's Name: _____ Subscriber's DOB: _____
Subscriber's Sex: M☐ F☐ Relationship to Subscriber: _____
Employer: _____ Employment Status: F/T☐ P/T☐ Retired☐

Hawaii Eye Institute
Queen's Medical Center, POB I
1380 Lusitana Street, Suite 604
Honolulu, HI 96813

In case of emergency please contact:

Name:_____ Relationship:_____

Primary Phone:_____ Work Phone:_____

Cell Phone: _____

RESPONSIBLE PARTY INFORMATION
(If different from patient information)

Last Name: _____First Name: _____M.I._____

Date of Birth:_____ Relationship: _____ Sex: Female ☐ Male ☐

Social Security #:_____ Retired: ☐ Yes ☐ No

Address: _____City:_____ State: ____ Zip: _____

Home Phone: _____Work Phone:_____

Cell Phone:_____Email: _____

Employer:_____Occupation:_____

I hereby authorize Gregory W. Schmidt, M.D. or his representative to release to my insurance company or representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I assign my insurance benefits including Medicare, HMSA and or any other health insurance plan payable to Gregory W. Schmidt, M.D. The assignment will remain in effect unless revoked by me in writing. **I understand that I am financially responsible for all charges whether or not paid by said insurance upon every visit.** I understand that there will be a $25.00 charge for appointments that I cancel without 24 hours prior notice and/or no show for the appointment.

Signature: _____ Date: _____
Patient or Legal Guardian

Hawaii Eye Institute
Queen's Medical Center, POB I
1380 Lusitana Street, Suite 604
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Dear Patients:

YOUR SAFETY IS IMPORTANT TO US

We would like you to take a few minutes to read and understand the following important information about eye examinations and some of the eye drops that are used during your eye examinations.

Once your eyes have been dilated, the following may occur for a period of time:

- Light sensitivity
- Glare
- Blurred Vision
- Difficulty Walking due to blurred vision
- Difficulty Driving due to blurred vision

Wearing dark glasses after dilation helps to ease some of these challenges, so…

PLEASE BRING DARK GLASSES WITH YOU TO ALL OF YOUR EYE EXAMS

It is strongly recommended that you avoid driving or operating dangerous machinery, and be extremely careful walking so that you do not injure yourself. We also suggest that you arrange for someone else to drive you home after dilation.

PLEASE CALL OUR OFFICE IMMEDIATELY if you should experience any of the following after your dilated exam with us: EYE PAIN, HEADACHE, and LOSS OF VISION

I have been informed, my questions have been answered and I understand the vision and safety problems associated with dilation. I will wear sunglasses following dilation and have arranged for transportation assistance.

This notice covers the period of time from my first visit to my last visit.

_____ _____

Patient Signature Date

_____

Print Name

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR

HAWAII EYE INSTITUTE

This authorization gives Gregory W. Schmidt, M.D and his associates permission to leave messages regarding my appointments or health information on my answering machine/voicemail. Gregory W. Schmidt, M.D. and his associates have my permission to speak to the following (spouse, family member, relative or friend) regarding my medical information and treatment.

Name	Relationship	Name	Relationship
_____	_____	_____	_____
_____	_____	_____	_____

I authorize the following **physicians** to make the authorized use and/or disclosure of my protected health information:

Name	Relationship	Name	Relationship
_____	_____	_____	_____
_____	_____	_____	_____

I hereby acknowledge that I have received and reviewed a copy of the Notice of Uses and Disclosures of Protected Health Information from Hawaii Eye Institute that details their Privacy Policy as required by the Health Information Portability and Accountability Act of 1996 ("HIPAA").

_____ _____

Signature Date

_____

Print Name

_____

Name of Personal Representative Relationship to Patient

PATIENT MEDICAL HISTORY

Name: _____ Age: _____ Date: _____

Internal Medicine Doctor: _____ Last Seen: _____

Optometrist/Ophthalmologist: _____ Last Seen: _____

Do you wear Glasses? (Yes / No) How old are they? _____

Circle One: Single Vision Bifocal Multifocal Readers

Please answer the following questions about your medical history:

List any medical conditions for which you have been treated (e.g., diabetes, high blood pressure, arthritis, etc.)

_____

List medications, including eye drops.

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Allergies: _____

Have you ever had any eye disease (e.g. glaucoma, cataract, wandering or "lazy eye", retinal detachment)?

_____

List any past surgeries, including eye surgery: _____

Do you smoke?	**Yes / No**	Social / Daily / Weekends
Do you drink alcohol?	**Yes / No**	Social / Daily / Weekends

Review of Systems

If you currently have any of the following problems please **circle:**

Fatigue	Vomiting	Depression	Abdominal pain
Chest Pain	Excessive Dry Skin	Sore Throat	Swollen Joints
Diarrhea	Weakness	Coughing	Paralysis
Skin Rashes	Weight loss/gain	Bloody Urine	Others: _____
Headaches	Sinus Problems	Joint Pain	
Anxiety	Wheezing	Numbness	_____
Hearing Loss	Urinary Discomfort	Irregular Heart Beat	_____
Shortness of Breath	Muscle aches	Heartburn	_____

PATIENT AND FAMILY HISTORY:

Have you or your family has been diagnosed with the following:

	PATIENT		FAMILY	
	YES	NO	YES	NO
Arthritis	_____	_____	_____	_____
Asthma	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Cataract	_____	_____	_____	_____
Diabetes *Type I or Type II*	_____	_____	_____	_____
Gastrointestinal	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____
Head and Neck Problems	_____	_____	_____	_____
Heart Problems	_____	_____	_____	_____
Heme/Lymph Bleeding	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Lazy Eye	_____	_____	_____	_____
Lungs/Respiratory	_____	_____	_____	_____
Macular Degeneration	_____	_____	_____	_____
Neurological Problems	_____	_____	_____	_____
Psychosocial	_____	_____	_____	_____
Retinal Detachment	_____	_____	_____	_____
Skin Problems	_____	_____	_____	_____
Urinary Problems	_____	_____	_____	_____