DR. KOBAYASHI

960 Center St. Rm. 2 * Wahiawa * HI * 96786
Ph: 808-622-4121 * Fax: 808-621-5041 * Email: info@doctorart.com

PERSONAL

Patient____

Patient SS#____________________ Birth Date____________________ Age________ Sex: F M

Address______________________________City____________________State________Zip__________

Email______________________________ ok to email? Marital Status: Single / Married / Widowed/ Other/ Spouse ___________

Phone: Home__________________ Cell______________________ ok to text ? Bus_____________________

Occupation_____________________________________ Employer_____________________________________

Emergency Contact_______________________ Relationship_________________ Phone__________________

Whom may we thank for referring you? ____

INSURANCE

Vision Insurance________________________________ Subscriber's Name_______________________________

Birth Date_______________ SS#__________________ Sex: F M Relationship_________________

Secondary Vision Insurance______________________________ Subscriber's Name______________________

Birth Date_______________ SS#__________________ Sex: F M Relationship_________________

Medical Insurance________________________________ Subscriber's Name_____________________________

Birth Date_______________ SS#__________________ Sex: F M Relationship_________________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage as written above and assign directly to Dr. Arthur Kobayashi all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____ ________________________ ________________

Responsible Party Signature Relationship Date

____
Patient Name

EYE HEALTH

Date of last eye exam__________ Do you wear glasses? Fulltime / Reading / Driving / Other________
Do you wear contacts? Full-time / Part-time / Sports / Other______________________________
Brand/power of CL's____
List all current or past eye diseases, eye injuries, or eye surgeries____________________________
Current eyedrops______________________ Hobbies____________________________
Reason for your visit____
Please check the box if you have any of the following:

Blurred vision-distance	Floaters and/or flashes
Blurred vision-near	Glaucoma
Burning eyes	Headaches
Itchy eyes	Light sensitivity
Discharge from the eyes	Loss of vision
Dizziness	Migraine headaches
Double vision	Red eyes
Dry eyes	Watering eyes
Eye strain	Twitching eyelid
Macular degeneration	Retinal disorder

OTHER____

MEDICAL HISTORY

Physician's Name______________________________ Date of last visit________________
Allergies to medications____
List all medications you are taking____
Pharmacy______________________________ Phone____________________________
Tobacco use? Alcohol use? Are you pregnant? # of children________________
Please check the box if you or a family member have any of the following:

	SELF	FAMILY		SELF	FAMILY
Weight loss			Diabetes		
Weight gain			Kidney disease		
Fatigue			Hepatitis (Type____)		
Fever			Osteoarthritis		
Sinus			Rheumatoid arthritis		
Asthma			Shingles		
Allergies			Rheumatic Fever		
Emphysema			Anemia		
Bronchitis			Blood disorders		
Breathing disorders			Tuberculosis		
Wheezing			Skin conditions		
Hypertension			Lupus		
Heart disease			Epilepsy		
Artificial heart valve			Parkinson's disease		
Pacemaker			Alzheimer disease		
AIDS/HIV			Migraine headaches		
Lazy eye			Cancer		
Glaucoma			Ulcers		
Cataracts			Constipation or diarrhea		
Macular degeneration			Elevated cholesterol		

OTHER____

Please email, info@doctorart.com , or fax, 808-621-5041, forms back to our office.

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. The use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosure of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party billing agent or vendor for processing claims or obtaining payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our Notice of Privacy Practices. This Notice will be updated whenever our policy practices change. You can get an updated copy here at the office or from our website.

When you sign this consent document, you signify that you agree that we can and will use and disclosure your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our Notice of Privacy Practices.

I have read this document and understand it. I consent to the use and disclosure of my health information for purpose of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Arthur T. Kobayashi, O.D., Inc.

Signature ______________________ Relationship to Patient ______________________ Date ______________________

Source of Authority: ____

We provide our patients the option to participate in our online patient communication system. Some of the features include the ability to:

- Request Appointments Online
- Confirm Appointments via Email
- Receive Text Message Appointment Reminders
- Submit Patient Satisfaction Surveys
- Refer Your Friends Online

You may opt-out of communications at any time by clicking the unsubscribe link in the footer of each email or by replying to a text message with 'STOP'. Standard Text Messaging rates apply.

Email Address: ______________________________

Cell Phone: ______________________________

Please sign below that you agree to allow us to use this information in providing your services.

Signature ______________________ Date ______________________