CLEAR

MAUI OPTOMETRY

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Name (Last, First, MI)_____ (Mr./Mrs./Ms./Dr.) Date of Birth _____

Primary Care Physician_____ Last Eye Exam Date _____

Previous Eye Doctor _____ Last Medical Exam _____

Employer/School _____ Occupation _____

Preferred Language _____ Ethnicity (Optional) _____ Male ☐ / Female ☐

Contact Information (Please check preferred form of contact)

Home _____ Cell _____ Email _____

Work _____ Address _____

Please hand ALL insurance cards to the receptionist.

Vision Insurance Plan _____

Member ID/Subscriber ID _____

Subscriber Name _____

Date of Birth _____

Medical Insurance Plan _____

Member ID/Subscriber ID _____

Subscriber Name _____

Date of Birth _____

Secondary **Vision** Insurance Plan _____

Member ID/Subscriber ID _____

Subscriber Name _____

Date of Birth _____

Secondary Medical Insurance Plan _____

Member ID/Subscriber ID _____

Subscriber Name _____

Date of Birth _____

Optical History

Do you wear glasses? Yes ☐ No ☐

Used for? _____

Do you wear contact lenses? Yes ☐ No ☐

If yes, what brand? _____

Would you like to be evaluated for contacts? (Additional fee may apply) Yes (Initial) _____

What is the reason for today's visit? Check all that apply. If you are a returning patient, please initial and date reason for coming in.

☐ Blurry distance vision _____

☐ Flashes of light or new floaters _____

☐ Headaches _____

☐ Difficulty with small print (near) _____

☐ Itchy eyes _____

☐ Other: _____

☐ Dry eyes _____

☐ Redness _____

Dilated eye exam

As a part of your comprehensive eye exam, your eyes will be dilated. If you choose NOT to be dilated you may defer by initialing and letting the doctor and staff know. You can choose to be rescheduled for the dilation portion of the exam on a day of your convenience. **Please initial one choice.**

CHOOSE to have dilated eye exam _____

RESCHEDULE the dilated eye exam _____

REFUSE the dilated eye exam. I take all responsibility for the consequences. _____

PLEASE COMPLETE BACK SIDE

Social History (Circle if applicable)

☐ Tobacco: Never / Former / Light (1-9 daily) / Heavy (9+ daily) / Vape/Smokeless

☐ Alcohol: None / 1-2 drinks daily / Social use only / Alcohol dependence

☐ Narcotic: None / Recreational / Chemical depencence

Nursing or pregnant (if applicable) **Yes** ☐ / **No** ☐

Medical History

If NONE, check here ☐

CIRCLE conditions below if you have or have had symptoms in the following areas and briefly explain.

Past Ocular History: glaucoma / cataract / macular degeneration / surgery / retina	
Constitution: developmental disorders / cancer / fatigue syndrome	
Ears, Nose, Throat: hearing loss / sinusitis / dry mouth / laryngitis	
Neuro: multiple sclerosis / epilepsy / cerebral palsy / tumor / stroke / migraine	
Psych: depression / attention deficit / anxiety disorder / bipolar disorder	
Cardio: hypertention / heart disease / vascular disease / congestive heart failure	
Respiratory: Cigarette smoker / asthma / bronchitis / emphysema chronic obstruction / sleep apnea	
Gastrointestinal: chron's / colitis / ulcer / acid reflux / celiac disease	
Genitourinary: kidney / prostate disease / cancer / STD / herpes / chlamydia	
Musc/Skel: osteoarthritis / arthritis / fibromyalgia / muscular dystrophy / ankylosing spondylitis / osteoporosis / gout	
Integumentary: eczema / psoriasis / rosacea / shingles	
Endocrine: thyroid dysfunction / hormonal dysfunction	
Diabetes: Type 1 / Type 2	**Last A1c:** **Percent:** **Date:**
Hem/Lymph: anemia / large blood loss / ulcer / cholesterol	
Allergic/Immunologic: drug allergies / enviromental allergies / lupus rheumatoid arthritis / sjogren's syndrome	

Medication List ☐ I have a list (Please give to staff)

Medication	Strength	Frequency taken

Family History (Please check all that apply and list relation)

☐ Cancer _____ ☐ High blood pressure _____ ☐ Diabetes _____ ☐ Stroke _____

☐ Macular degeneration _____ ☐ Glaucoma _____ ☐ Cataracts _____ ☐ Other _____

Financial Responsibility - Medical Information Release - HIPAA

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand I am financially responsible for any balance. I authorize Maui Optometry or insurance companies to release any information required to process claims. I also acknowledge that I have been given notification of my HIPAA privacy rights.

_____ _____

Parent/Guardian Signature **Date**

By signing below I confirm that my information is CURRENT and there have been NO CHANGES to my medical conditions or insurance

Signature	**Date**	**Signature**	**Date**