**Vivien Tham, M.D.**
Pacific Vision Institute of Hawaii
1401 South Beretania Street Suite 560
Honolulu, HI 96814
Phone (808) 428-3288
Fax (808) 312-6308

## SECTION 1 Personal Info

Patient Name ______________________________________________________________
Last First MI Nickname

Address ______________________________________________________State___ Zip ________________

Date of Birth __________________ ☐Male ☐Female Social Security No. ______________________________

Cell # ( )_____ - ___________ Home # ( )_____ - ___________ Work # ( )_____ - ____________

Email ______________________________________________ Occupation _____________________________________

Primary Care Dr. ____________________________________ Retired ☐Yes ☐No

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Preferred Language ☐ English ☐ Cantonese ☐ Mandarin ☐ Specify ____________________________

## SECTION 2 EMERGENCY CONTACT

Name ______________________________Phone# ( )_______-____________Relationship _________________

Name ______________________________Phone# ( )_______-____________Relationship _________________

## SECTION 3 AUTHORIZATION FOR RELEASE (If you would like us to discuss your confidential medical information with anybody else such as your children, please list)

I authorize release of confidential medical information to the following contact persons

Name ______________________________Phone# ( )_______-____________Relationship _________________

Name ______________________________Phone# ( )_______-____________Relationship _________________

I hereby authorize Pacific Vision Institute of Hawaii to release all medical information regarding my illness, care and/or injury to my insurance carriers, any healthcare facility, and any other physician that would benefit my health care. I hereby assign my insurance benefits including Medicare, HMSA and or any other health insurance plan payable to Pacific Vision Institute of Hawaii. 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. A copy of this assignment is as valid as the original.

***Please note that an estimated office co-payment will be collected on the day of service. A final bill will be sent to you after insurance claims are finalized.***

Signature of Patient/Legal Guardian ____________________________________Date ______________________

confidential

# Review of System (Answer the best you can)

**Reason for your visit today** ______________________________

**Who referred you here today** ______________________________

**Preferred pharmacy (name & address)** ______________________________

**Other medical doctors** Name ______________ Specialty __________ Phone __________

Name ______________ Specialty __________ Phone __________

**Do you have any of the following eye problems?**

Please Circle

| | | |
|---|---|---|
| Difficulty reading | Eye Pain | Glaucoma |
| Difficulty driving | Dry Eye | Cataract |
| Glare | Eye Redness | Diabetic Eye Disease |
| Flashing lights | Eye Discharge | Macular Degeneration |
| Floaters | Tearing | Retinal Detachment |
| Double Vision | Itchy Eye | Trauma to Eye |
| Vision Loss | Swollen Lids | Lazy Eye |

**Other eye problems** ______________________________

**Allergies/Reaction** ______________________________

**Do you wear glasses?** ☐ No IF Yes ☐ → Age of glasses?______ ☐ *Single* ☐ *Multifocal* ☐ *Readers*

**Do you wear Contact Lenses?** ☐ No IF Yes ☐ → ☐ Hard ☐ Soft ☐ Multifocal

Left Eye Contact Brand ______________ Power ________ BC ________ Diameter ________

Right Eye Contact Brand ______________ Power ________ BC ________ Diameter ________

**Have you ever had eye surgery or laser surgery?**

Please Circle

| | | | | |
|---|---|---|---|---|
| Cataract Surgery | Left | Right | Dr.______________ | Date ______ |
| Retinal Detachment Surgery | Left | Right | Dr.______________ | Date ______ |
| Eye Lid Surgery | Left | Right | Dr.______________ | Date ______ |
| LASIK/PRK | Left | Right | Dr.______________ | Date ______ |
| Laser for Glaucoma | Left | Right | Dr.______________ | Date ______ |
| Macular Degeneration | Left | Right | Dr.______________ | Date ______ |

Other eye surgeries ______________________________

**Eye Medication (if any)** (*which eye, name, strength, dosage)*

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

 confidential

# Medical History

**Please circle if you have any of these medical conditions and explain what type**

Please Circle

**Diabetes** ***Type I or II*** **Cancer** ____________________

**High Cholesterol** __________ **Auto immune Disease** __________

**Heart Problems**___________ **Thyroid Problems** ____________

**Others medical history** _______________________________________________

**Other non-eye related Surgeries** *(type & date)*

_______________________________________________

**Current Prescription Medication(s)** (*name, strength, dosage)*

__________________________ __________________________

__________________________ __________________________

__________________________ __________________________

**Please circle if any of your family members had any of these medical conditions**

Please Circle

| | | |
|---|---|---|
| **Arthritis** | **High Blood Pressure** | **Cataracts** |
| **Diabetes** | **Heart Disease** | **Blindness** |
| **Stroke** | **Macular Degeneration** | **TB** |
| **Cancer** | **Kidney Disease** | **Other/Explain** |
| **Glaucoma** | **Retinal Disease** | _______________ |

## Social History

**Cigarettes smoke**? _______ Pack per day? _________ How many years? ________

**Drink Alcohol**? _______ Drink per day? _________

**Past/Present Drug use** (legal or illegal) ☐ No ☐ Yes

Drug(s) Used ______________________________ Frequency _______________

**Is there anything not mentioned on this form that you would like the doctor to be aware of?**

_______________________________________________

Your eyes will be dilated for your exam. Dilation will make the pupils of your eyes large for several hours and can cause *light sensitivity, glare,* and *blurred vision*. Dark glasses are recommended. If you do not have your own, please ask us for a pair.

**Patient's Signature** ________________________________ **Date** ______________

Please (Circle) any matching condition     Patient Name: ______________________.

**Eyes**

Previous Surgery
Contact Lens
Pain
Double Vision
Glaucoma
Cataracts
Macular Degeneration
Dry Eyes
Flashes
Floaters

**Ear, Nose and Throat**

Hard of Hearing
Ringing in Ears
Vertigo

**Cardiovascular**

Chest Pain
Dizziness
Fainting Spells
Shortness of Breath
Irregular Heart Beat
Difficulty Lying Flat

**Constitutional**

Fatigue/Weakness
Fever
Weight Gain/Loss

**Respiratory**

Cough
Congestion
Wheezing
Asthma

**Gastrointestinal**

Heartburn
Nausea/Vomiting
Jaundice/Hepatitis

**Genito-Urinary**

Pain/Difficulty
Blood in Urine
History of Kidney Stones
History of STDs

**Psychiatric**

Anxiety/Depression
Mood Swings
Difficulty Sleeping

**Endocrine**

Increased Thirst
Increased Hunger
Increased Urination
Increased Sweating
Fingernail Changes

**Blood/Lymphnodes**

Easy Bruising
Gums Bleed Easily
Prolonged Bleeding
Heavy Aspirin Use

**Musculoskeletal**

Stiffness
Arthritis
Joint Pain/Swelling

**Skin**

Rash/Sores
Lesions
Hives/Eczema

**Neurological**

Seizures
Weakness/Paralysis
Numbness
Tremors

**Immunologic**

Hives
Itching
Runny Nose
Sinus Pressure

**Vivien Tham, M.D.**
Pacific Vision Institute of Hawaii
1401 S Beretania Street, # 560
Honolulu, HI 96814
Phone (808) 428-3288

# Acknowledge of Receipt
# The Notice of
# Uses and Disclosures of Protected Health Information

I have read the Notices of Uses and Disclosures of Protected Health Information (the "Notice") that is posted in your office. I hereby acknowledge that I received this Notice from Vivien Tham, M.D. (Pacific Vision Institute of Hawaii).

**Patient's Signature** ________________________________________ **Date** ________________

# Notice to Patient Fee

**1. Refraction charges may or may not be covered depending on your medical insurance plan**

**Your comprehensive eye exam is covered by your medical plan**, However, Some medical plans consider refraction a "vision" service not a 'medical" service. Our office fee for refraction is **$50**. We will bill your insurance company for all services rendered today including the refraction.
If your insurance company does not pay for the refraction, the refraction fee will be collected in addition to any co-payment, coinsurance or deductible.

For patients who have VSP as your vision plan, we cannot bill VSP directly. You are responsible for paying **$50** to our office first and sending a receipt to VSP for reimbursement.

Please call your insurance company if you have a question regarding your plan's coverage.

**2. Fee for late cancellation and no-show fee**
**Please call us 24 hours in advance to cancel your appointment, A no-show or late-cancellation fee of $50 WILL BE assessed.**

**3. Fee for returned checks $50**

**4. I am aware and agree that I will be charged a fee for any contact lens fitting exam**.

By signing this form, I acknowledge receipt of this fee notice.

**Patient's Signature** ________________________________________ **Date** __________________