Windward VISION Center

Dr. Gerald M. Matsuda **Dr. Stuart K. Machida** **Dr. Kari J.Y. Chang-Moses**

WELCOME TO OUR OFFICE! Please complete this form as accurately as possible. Please print.

☐ Male ☐ Female ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Master

Last Name _____ First _____

Middle Initial(s) _____ Nickname _____

Mailing Address _____

City _____ State _____ Zip _____

Home Address (if different) _____

Home Phone _____ Work Phone _____ Cell Phone _____ Texting Ok? ☐ Yes ☐ No

E-mail _____ Preferred method of contact: ☐ Email ☐ Postal ☐ Phone Home Work Cell

Employer (Or School) _____ Occupation (Or Grade) _____

Birthdate _____ Marital Status _____ Name of Spouse _____

Name of Responsible Person of Account _____ Relationship _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referred By: _____

Race
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Other

Ethnicity
- ☐ Hispanic or Latino
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Not Hispanic or Latino

Preferred Language
- ☐ English
- ☐ Spanish
- ☐ Other

Collecting race, ethnicity, and language data helps promote equity through enhanced patient-provider communication and the provision of evidence-based quality care. Achieving the goals of quality care requires monitoring to ensure that all populations receive patient-centered, safe, effective, timely, efficient, and equitable care.

INSURANCE INFORMATION (Write "None" if no insurance)

	Company	Subscriber	Membership #
Primary Vision Insurance			
Second Vision Insurance			
Primary Medical Insurance			
Second Medical Insurance			

I authorize the release of any medical information necessary to process any claims(s) to my insurance company, social security administration, or any of the above named insurances. I request all payments under the insurance program be made to me or to the provider for services and materials furnished to me during the effective period of this authorization. This assignment will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges incurred and in the event that insurance payments are sent directly to me, I will remit payment to this office. If my insurance does not pay all bills submitted, I acknowledge that these bills are my responsibility and will guarantee payment. I further agree to pay any reasonable cost, including attorney and collection agency cost, in the event my account becomes delinquent.

Print Name (patient or parent/guardian) _____ Patient Signature (or parent/guardian) _____ Date _____

(OVER)

Windward Mall
46-056 Kamehameha Highway
Kaneohe, HI 96744

Kailua Professional Building
30 Aulike Street, Suite 102
Kailua, HI 96734

Patient HEALTH History

Dr. Gerald M. Matsuda **Dr. Stuart K. Machida** **Dr. Kari J.Y. Chang-Moses**

Name

Reason For Visit : ☐ Check Up *(No Difficulty, Seeing Clearly And Comfortably)*
☐ Seeing Or Eye Problem *(Please Explain)* _____

How Long Ago Was Your Last Complete Eye Exam? _____ Dilated ☐ Yes ☐ No
Who Was Your Last Eye Doctor? _____ Who Is Your Primary Care Physician? _____
Do You Wear Glasses? ☐ Yes ☐ No How Old Are Your Present Glasses? _____

Have You Ever Worn Contact Lenses? ☐ Yes ☐ No
Do You Currently Wear Contact Lenses? ☐ Yes ☐ No ☐ Sometimes
State Contact Lens Type (Brand, Base Curve, Diameter, Power) _____
If No, Are You Interested In Wearing Contact Lenses? ☐ Yes ☐ No ☐ Maybe

Are You Currently Taking Any Drugs Or Medications?
☐ Yes ☐ No *(If Yes, please list)*

Are You Allergic To Any Drugs Or Medications?
☐ Yes ☐ No *(If Yes, please list)*

Have You Ever Had Any Eye Disease, Eye Injury, Or Eye Surgery? ☐ Yes ☐ No *(If Yes, please describe)*

Do You Currently Smoke? ☐ Yes ☐ No Have You Ever Smoked Before? ☐ Yes ☐ No Height _____
Do You Drink Alcohol? ☐ Yes ☐ No Do You Use Recreational Drugs? ☐ Yes ☐ No Weight _____

Do You Have Any Of The Following Problems/Conditions (Please List):

YES	NO		
☐	☐	Allergy	*(Hay Fever, Atopy, Etc.)* _____
☐	☐	Cardiovascular	*(High Blood Pressure, Cholesterol, Heart Problems, Etc.)* _____
☐	☐	Constitutional	*(Fever, Weight Loss/Gain, Fatigue, Etc.)* _____
☐	☐	Endocrine	*(Diabetes, Hormone, Thyroid, Etc.)* _____ *If Diabetes: Type I or II*
☐	☐	Gastrointestinal	*(Hernia, Ulcers, Acid Reflux, Etc.)* _____
☐	☐	Genitourinary	*(Bladder Infection, Kidney Stones, Prostate, Etc.)* _____
☐	☐	Head (Ears, Nose, Mouth, Throat)	*(Hearing Loss, Cough, Congestion, Dry Mouth, Etc.)* _____
☐	☐	Hematologic/Lymphatic	*(Anemia, Blood Disorder, Bleeding Problems Etc.)* _____
☐	☐	Integumentary	*(Skin, Rashes, Acne, Eczema, Etc.)* _____
☐	☐	Musculoskeletal	*(Arthritis, Joint, Osteoporosis, Etc.)* _____
☐	☐	Neurological	*(Multiple Sclerosis, Headaches, Migraines, Etc.)* _____
☐	☐	Psychiatric	*(Anxiety, Depression, ADHD, Bi-Polar, Etc.)* _____
☐	☐	Respiratory	*(Asthma, Emphysema, Bronchitis, Etc.)* _____
☐	☐	Currently Pregnant/Nursing	

Do You Have Any Family History Of: *(Please List Family Member)*

Amblyopia _____ Diabetes _____
Blindness _____ High Blood Pressure _____
Cataracts _____ High Cholesterol _____
Eye Surgery _____ Cancer _____
Glaucoma _____ Other _____
Macular Degeneration _____
Other Eye Problems _____

I ACKNOWLEDGE THAT I RECEIVED A COPY OF WINDWARD VISION CENTER'S NOTICE OF PRIVACY PRACTICES.

_____ _____
Signature Date