

PATIENT INFORMATION

Name: _____ Sex: Male Female
Birth Date: _____ Marital Status: Married Single Divorced Widowed Other
Address: _____ City: _____ State: _____ ZIP: _____
Email: _____ Preferred Phone: _____
Emergency Contact: _____ Phone: _____ Relationship: _____
How did you hear about us?
 I live/work in area Social media I was referred by _____ Other _____

INSURANCE INFORMATION

VISION INSURANCE-PRIMARY

Name of Insurance Company: _____ Policy Holder Name: _____
Member ID: _____ Birth Date: _____ Relationship: Self Child Spouse Other

VISION INSURANCE-SECONDARY

Name of Insurance Company: _____ Policy Holder Name: _____
Member ID: _____ Birth Date: _____ Relationship: Self Child Spouse Other

MEDICAL INSURANCE- PRIMARY

Name of Insurance Company: _____ Policy Holder Name: _____
Member ID: _____ Birth Date: _____ Relationship: Self Child Spouse Other

MEDICAL INSURANCE- SECONDARY

Name of Insurance Company: _____ Policy Holder Name: _____
Member ID: _____ Birth Date: _____ Relationship: Self Child Spouse Other

I, the undersigned, certify that I (or my dependent) have insurance coverage as written above and assign directly to Dr. Rebecca Cabatbat 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 use of this signature on all insurance submissions.

Patient Signature

Date

REASON FOR VISIT

Check all that apply:

Pain Blur Double Vision Headache Redness Itchiness Dryness Spots

Other: _____

Which eye?

Right
 Left
 Both

Severity

Mild
 Moderate
 Severe

Duration: for how long have you been experiencing these symptoms?
 Please include any additional info you think may be helpful:

EYE HEALTH & MEDICAL HISTORY

Date of Last Eye Exam: _____ Do you wear glasses? Yes/No Fulltime Reading Distance

Do you wear contacts? Yes/No Fulltime Part-time Sports Other Brand/Power of Contacts: _____

List all current or past eye diseases, eye injuries, or eye surgeries: _____

Current Eye Drops: _____ Hobbies: _____

Physician's Name: _____ Allergies to medications: _____

Pharmacy/Location: _____

Medications you're currently taking:

Tobacco Use? Yes/No

Alcohol Use? Yes/No

Are you currently pregnant? Yes/No

Please check appropriate box below if you or a family member have any of the following:

	Self	Family		Self	Family
Shingles	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Seizures Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Elevated cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Anemia Blood	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Disorder Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			

Patient Symptom Questionnaire

Please check all symptoms you are currently experiencing. This helps us determine whether your visit is routine or medical in nature.

Visual Symptoms

- Blurry Vision (sudden or gradual)
- Double Vision
- Loss of Vision (partial or complete)
- Flashes of light
- New or increased floaters
- Difficulty seeing at night
- Trouble focusing

Eye Discomfort

- Eye pain or pressure
- Headaches around the eyes
- Eye strain or fatigue
- Foreign body sensation (feeling like something is in the eye)

Surface/Ocular Health Symptoms

- Dryness or burning
- Itching
- Excessive tearing/watering
- Redness
- Light sensitivity
- Discharge or crusting

Other Concerns

- Injury or trauma to the eye
- History of eye surgery
- Diabetes (Includes Borderline and Pre-Diabetes)
- Hypertension
- Other systemic conditions
- Glaucoma
- Current use of eye medications (drops or ointments)

Cataract

Insurance & Billing Notice:

Some symptoms may indicate medical conditions that require billing to your medical insurance instead of your routine vision plan. If today's visit is determined by the doctor to be medical in nature, your medical insurance will be billed. You will be responsible for any copayments, deductibles, or non-covered services in accordance with your insurance policy.

By signing below, you acknowledge that you have read and understand this policy.

Patient

Signature: _____

Date: _____

Rebecca L. Cabatbat, OD, INC.
Central Oahu Eye Care
960 Center St. Suite 2 Wahiawa, HI 96786
P: 808-622-4121 F: 808-621-5041
Email: info@cabatbatod.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

The Notice of Privacy Practice 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 services 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 disclose 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 the purpose of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Rebecca L. Cabatbat, OD, Inc.

Signature

Date

Relationship to Patient

We provide our patients the option to participate in our online patient communication system. Some features include: appointment reminders, appointment confirmations, two-way text messaging, re-care and follow up reminders.

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.

I consent to receive automated and manual communications from Central Oahu Eye Care via text message, email, and/or phone through Demandforce. These may include appointment reminders, health updates, surveys, and special offers. I understand I can opt out at any time.

Signature

Date



The Optomap® (digital image of the retina)
will be done annually for every patient
UNLESS a waiver is signed.

Our doctors recommend all patients of all ages to have a digital image of the retina done annually, with the advanced scanning digital imaging system. This is doctor's preferred method to evaluate the inside of your eyes. This image becomes a permanent part of your medical record.

Eye conditions such as macular degeneration, glaucoma, and retinal disease now can be seen without dilation for most patients.

Early detection is crucial!

The fee for this is only \$29 (It is usually not covered by insurance)

* *(Please circle your choice below)**

YES I have been informed of the Optomap and the additional cost and choose to have the image taken today and understand that I may still need to be dilated if necessary.

NO I have been informed of the Optomap and I choose to decline having this image taken. I do understand that I may be dilated today which may cause me to have blurred vision and light sensitivity for 3-4 hours.

Patient Name _____

Parent/Guardian Name _____

Signature _____ Date _____



BROKEN APPOINTMENT FORM

Our office values your time and takes great effort to stay on schedule to see you at the time of your scheduled appointment. We feel that our time is just as valuable, so we request a 24-hour notice for all cancelled appointments.

If you do not show up for your scheduled appointment or give us a 24-hour cancellation notice, we will charge a **\$50.00 cancellation fee** for each broken appointment.

We appreciate your cooperation and understanding.

Patient Name

Patient Signature

Date



Contact Lens Evaluation & Policy

In order to maintain the highest standards for your ocular health, all patients interested in wearing contact lenses must undergo a contact lens specific evaluation and fitting. This goes for new and existing contact lens wearers. Contact lenses are considered FDA-approved medical devices so this evaluation ensures that your eyes are healthy enough to begin or continue wearing contact lenses. This evaluation must be done annually and is considered a separate service from the general eye health examination.

During the contact lens examination, follow-up visits may be necessary to trial new lenses and/or monitor eye health. All follow up visits must be completed within 90 days of your initial contact lens fitting to finalize your contact lens prescription and to avoid additional fees.

Contact lens Evaluation/Fitting Fee:

Spherical: \$94.24

Toric: \$115.18

Multifocal/Monovision:

Specialty: \$136.13

Insurance copay/allowance: _____

Contact lens after care: \$45

Should you need additional follow-up care after the 90-day allowance, a fee will be charged per after-care visit. This fee will cover additional follow-up visits for the next 30 days.

Contact lens insertion & removal training: \$50

Required for all patients who are new to contact lens wear. This one-on-one training is not included in standard evaluation and after-care visits.

I have read and understand the above fees and accept responsibility for the amount being charged for all applicable services being rendered today. I also understand that if my insurance is billed for my evaluation, it is my responsibility to pay for any remaining balance that is unpaid by my insurance. I am aware that the above fees are non-refundable and that my prescription for contact lenses will be released to me when the fitting process is complete and all fees have been paid

Patient Name: _____

Date: _____

Signature: _____

Guardian Name (if applicable): _____