**Izumi Yamamoto, MD**
Hawaii Eye Clinic, Inc.
1441 Kapiolani Blvd., Suite 1910
Honolulu, HI 96814
Tel: (808) 943-7000

# Confidential Billing and Release Information

## SECTION 1: TELL US ABOUT YOURSELF/ご本人情報

Patient Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ____________________________________________
Last First MI Nickname

Address: ____________________________________________

City, State, Zip: ____________________________________________

Date of Birth: ________________ ☐Male ☐Female Social Security No.: ________________________

Primary Phone: ( ) ________ - ____________ Cell Phone: ( ) ________ - ____________

Employer: ________________________ Occupation: ________________________

Work Phone: ( ) ________- ____________ Ext ____________

Referred By: ________________________ Primary Care Dr:________________________

Marital Status: ☐Married ☐ Single ☐ Divorced ☐Widowed

Ethnicity: ☐Japanese ☐ Caucasian ☐ Chinese ☐Korean ☐Filipino ☐ African American ☐ Hispanic ☐Mix

Preferred Language: ☐English ☐ Japanese

## SECTION 2: INSURANCE INFORMATION (Copy Required) /保険情報

**Primary Insurance**
Insurance Company: ________________________ ☐Self ☐Dependant

Subscriber's Name: ________________________ Subscriber's DOB:________________________

Relationship: ________________________

**Secondary Insurance**
Insurance Company: ________________________ ☐Self ☐Dependant

Subscriber's Name: ________________________ Subscriber's DOB:________________________

Relationship: ________________________

## SECTION 3: EMERGENCY CONTACT/緊急連絡先

Name: ________________________ Relationship: ________________________

Primary Phone: ( ) ________ - ____________ Cell Phone: ( ) ________ - ____________

Work Phone: ( ) ________- ____________ Ext ____________

**SECTION 4: RESPONSIBLE PARTY (if different from yourself)/未成年者などで、患者ご本人と支払い責任者が違う場合**

Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ______________________________________________
Last First MI

Address: ______________________________________________

City, State, Zip: ______________________________________________

Date of Birth: __________________ ☐Male ☐Female Social Security No.: ______________________

Relationship: ______________________________

Primary Phone: ( ) _________ - ______________ Cell Phone: ( ) _________ - ______________

Employer: ______________________________ Occupation: ______________________________

Work Phone: ( )_________ -______________ Ext ___________

**SECTION 5: 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: ______________________________ Name: ______________________________

Primary Phone: ( )_________-______________ Primary Phone: ( )_________-______________

Relationship: ______________________________ Relationship: ______________________________

I hereby authorize Izumi Yamamoto, M.D. or her representative to release to my insurance company or representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I assign my insurance benefits including Medicare, HMSA and or any other health insurance plan payable to Hawaii Eye Clinic, Inc. 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.

私はここに、ハワイアイクリニック, Inc.、山本いづみ, M.D. またはその代理人が、私の保険会社またはその代理人に対し、医療機密情報の開示をすることを承諾する。医療機密情報とは、このクリニックにておいて行われた検査や診察、診断内容、内科的あるいは外科的治療の内容、あるいは、保険請求に必要な個人情報を含む。私は Medicare など公的健康保険、HMSA など私的健康保険あるいは海外旅行保険の受取りをハワイアイクリニック, inc.に譲渡し、保険機関からの支払いが直接ハワイアイクリニック, inc.へいくことを承諾する。この保険支払いの譲渡は私が書面によって通知するまで有効である。保険機関の支払いの有無にかかわらず、私がハワイアイクリニック, Inc. で受けた医療費すべてに支払い責任があることを承諾する。

Signature of Patient/Legal Guardian:______________________________Date:________________

**Izumi Yamamoto, MD**
Hawaii Eye Clinic, Inc.
1441 Kapiolani Blvd., Suite 1910
Honolulu, HI 96814
Tel: (808) 943-7000

# Confidential Patient Medical History/病歴に関する質問書

Name/お名前: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ____________________ ____________________

Last/姓 First/名 MI

Occupation/職業: ______________________________ Hobbies/ご趣味: ______________________________

Referred by/紹介者:____________________________ Primary Care Dr./主治医: ____________________________

☐KZOO ☐ KIKU TV ☐ Nikkan San ☐ Lighthouse ☐ Website ☐ Yellow Page ☐ Friends and Family

## SECTION 1: EYE HISTORY/眼に関する病歴

Reason for visit/来院理由 : ______________________________________________________________

Do you wear glasses?/メガネをかけていますか?: ☐No ☐Yes
☐for distance/遠くを見る用 ☐for computer/コンピューター用 ☐for near/近く用

Do you wear contact lenses/コンタクトは使いますか? ☐No ☐Yes

**Do you have the following eye problems?/眼に関して以下の症状または病歴がありますか？**

| | | | | | |
|---|---|---|---|---|---|
| Tired eyes/眼が疲れる: | ☐N | ☐Y | Dry Eyes/ドライアイ: | ☐N | ☐Y |
| Eye pain, Redness/眼が痛い、赤目: | ☐N | ☐Y | Cataract/白内障: | ☐N | ☐Y |
| Eye discharge, Tearing/目やに、涙目: | ☐N | ☐Y | Glaucoma/緑内障: | ☐N | ☐Y |
| Itching, Sandy sensation/かゆみ、ごろごろ: | ☐N | ☐Y | Diabetes/糖尿病: | ☐N | ☐Y |
| Difficulty reading/本が読みにくい: | ☐N | ☐Y | Lazy eye/斜視、弱視: | ☐N | ☐Y |
| Difficulty driving/車の運転がしづらい: | ☐N | ☐Y | Macular degeneration/黄班変性症: | ☐N | ☐Y |
| Light sensitive, Glare/光がまぶしい: | ☐N | ☐Y | Retinal detachment/網膜はく離: | ☐N | ☐Y |
| Floaters/浮遊物がみえる: | ☐N | ☐Y | Swollen lids/まぶたが腫れる: | ☐N | ☐Y |
| Flashing lights/光がちらつく、閃光: | ☐N | ☐Y | Droopy eyelids/まぶたが垂れる : | ☐N | ☐Y |
| Double vision/物が二重に見える: | ☐N | ☐Y | Eye trauma/眼の外傷: | ☐N | ☐Y |

Other/その他:______________________________________________________________

**Have you had eye surgery or laser treatment?/眼の手術やレーザー治療を受けたことはありますか?**

| | | | | | |
|---|---|---|---|---|---|
| Cataract surgery /白内障手術: | ☐N | ☐Y | LASIK,PRK/レーシック: | ☐N | ☐Y |
| Glaucoma surgery/緑内障手術: | ☐N | ☐Y | Glaucoma laser/緑内障レーザー: | ☐N | ☐Y |
| Eye muscle surgery/斜視の手術: | ☐N | ☐Y | Diabetes laser/糖尿病網膜レーザー: | ☐N | ☐Y |
| Retinal detachment/網膜はく離の手術: | ☐N | ☐Y | Other laser/その他のレーザー: | ☐N | ☐Y |
| Eyelid surgery/まぶたの手術: | ☐N | ☐Y | Intraocular Injection/眼内注射: | ☐N | ☐Y |

Other/その他:______________________________________________________________

## SECTION 2: MEDICAL HISTORY/病歴

Do you smoke?/タバコは吸いますか? : ☐No ☐Yes ____ packs/day ☐ Used to smoke/昔吸っていた

Do you drink alcohol?/お酒は飲みますか? : ☐No ☐Yes ____________________ per day

**Allergy(Drugs, food, vog etc.)/アレルギー（薬、食品、火山灰他）:**____________________________________

**Do you have health problems or following symptoms?/以下の病歴、または症状がありますか？**

Fever, Weight loss/微熱、体重の減少: ☐N ☐Y
Hard of hearing/耳が遠い: ☐N ☐Y
Asthma, Emphysema/喘息、気管支拡張: ☐N ☐Y
Heart attack, Chest pain/心臓病: ☐N ☐Y
High blood pressure/高血圧: ☐N ☐Y
Headache/頭痛: ☐N ☐Y
Stroke/脳梗塞: ☐N ☐Y
High Cholesterol/高コレステロール: ☐N ☐Y
Diabetes/糖尿病: ☐N ☐Y

Thyroid problem/甲状腺異常: ☐N ☐Y
Stomach problem/胃の疾患: ☐N ☐Y
Prostate problem/前立腺疾患: ☐N ☐Y
Arthritis, Joint pain/リュウマチ、関節痛: ☐N ☐Y
Rash, Skin Cancer/発疹、皮膚がん: ☐N ☐Y
Autoimmune disease/自己免疫不全: ☐N ☐Y
Bleeding disorder/出血傾向: ☐N ☐Y
Cancer/がん: ☐N ☐Y
Allergy/アレルギー症状: ☐N ☐Y

Other/その他: ______________________________________________________________

Surgery other than the eye?/眼以外の手術をしたことがありますか? ☐N ☐Y ___________________________

Recent hospitalization?/最近入院したことはありますか? ☐N ☐Y ___________________________

## SECTION 3: ご家族の病歴 －血縁関係のご家族の中に以下の病気の方はいらっしゃいますか？

Glaucoma/緑内障: ☐N ☐Y
Nignt blindness/Blindness 夜盲症、失明: ☐N ☐Y
Strabismus, Amblyopia 斜視、弱視: ☐N ☐Y
Macular Degeneration/黄班変性症: ☐N ☐Y

Diabetes/糖尿病: ☐N ☐Y
Hypertension/高血圧: ☐N ☐Y
Heart Disease, Stroke/心臓病、脳梗塞: ☐N ☐Y
Cancer/がん: ☐N ☐Y

Other/その他:______________________________________________________________

## SECTION 4: CURRENT MEDICATIONS/現在使われているお薬

| **EYE MEDICATIONS/点眼薬** | | |
|---|---|---|
| Name 名前 | L or R 左右 | How often 頻度 |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| **ORAL MEDICATION/内服薬** | |
|---|---|
| Name 名前 | How often 頻度 |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

# Dry Eyes Questionnaires/ドライアイに関する質問書

**Have you been diagnosed with Dry Eye Disease?**
**/今までにドライアイと診断されたことはありますか?** ☐ Yes ☐ No

**Do you have any of the following symptoms?**
**/以下のような症状はありますか?** ☐ No

☐ On and off blurry vision/かすんで見える
☐ Redness/目が赤い
☐ Burning/目がしみる
☐ Itching/目がかゆい
☐ Light sensitivity/光を眩しく感じる
☐ Excessive tearing/涙目
☐ Tired eyes/目が疲れる
☐ Mucous or discharge/目やにが出る
☐ Feeling of sand in the eye/目に異物感
☐ Contact lens discomfort/コンタクトの異物感

**Any of these symptoms related to the following conditions?**
**/そのような症状は以下のようなときに良く起こりますか?** ☐ No

☐ Windy conditions when outside/風がよく吹いているとき
☐ Low humidity (air conditioning, airplanes)/湿度が低いとき(飛行機、エアコンがかかった部屋)
☐ While using computers, watching TV, reading/コンピューター、読書、テレビを見ているときなど

**Do you use the following?/以下のようなものを使いますか?** ☐ No

☐ Contact lens/コンタクトレンズ
☐ Over the counter eye drops/市販の目薬（人工の涙、目をすっきり白くする充血を取る薬、など）
☐ Glaucoma eye drops/緑内障の目薬
☐ Anti-allergy eye drops or allergy pills/アレルギー用の目薬あるいは飲み薬

**Have you had 今までに以下のような手術をされたことはありますか?** ☐ No

☐ Cataract surgery/白内障の手術
☐ LASIK or PRK/視力矯正手術（レーシック、PRK など）
☐ Eyelid surgery/まぶたの手術（二重まぶたの手術、まぶたを上げる手術）

I review this form and based on the information contained therein and other available clinical data, I suspect that this patient has Dry Eye Disease and obtaining a tear osmolarity measurement is medically necessary for the diagnosis and management of this patient's ocular problem(s).

Attending physician: ___________________________________ (Izumi Yamamoto, MD)

**Izumi Yamamoto, MD**
Hawaii Eye Clinic, Inc.
1441 Kapiolani Blvd., Suite 1910
Honolulu, HI 96814
Tel: (808) 943-7000

# Notice to Patient

**1. Refraction charges**

One of the most important parts of your eye exam today is refraction. This test helps determine whether you have refractive errors, such as nearsightedness, farsightedness, or astigmatism. Refraction helps the doctor determine the best possible visual acuity and function of your eye. Although **your comprehensive eye exam is covered by your medical plan**, refraction may or may not be a covered service depending on your medical insurance plans. Some medical plans consider refraction a "vision" service not a "medical" service. Our office fee for refraction is **$30.** 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.

If you have a vision plan, refraction will be covered under medical or vision plan. For patients who have VSP as your vision plan, we cannot bill VSP directly. You are responsible for paying $30 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**

If you would like to cancel your appointment, please call us 24 hours in advance. A no-show or late-cancellation fee of **$35** may be assessed.

**3. Fee for returned checks**

**$15** will be assessed for all returned checks.

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

___________________________ _________________________ ________

Patient's name (printed) Signature (or legal guardian) Date

## Acknowledgement of Receipt of Notice of Uses and Disclosures of Protected Health Information for Izumi Yamamoto, M.D. (Hawaii Eye Clinic, Inc.)

I was given a copy of 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 Izumi Yamamoto, M.D. (Hawaii Eye Clinic, Inc.).

_________________________ ________

Signature (or legal guardian) Date