



PATIENT REGISTRATION INFORMATION

NAME: _____
LAST FIRST MI

Address: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Other Phone: _____ Email Address: _____

Birthdate: _____ Sex: M F Social Security No. _____

Employer: _____ Marital Status: Married Divorced Single
Widowed Separated Other

Primary Physician: _____

Who referred you?: _____

Persons to Contact in Emergency:

Primary Contact: _____ Relationship: _____ Telephone: _____

Secondary Contact: _____ Relationship: _____ Telephone: _____

RESPONSIBLE PARTY

Party Responsible for Payment: Self Spouse Parent Other

Name (if other than self): _____

Address: _____

City: _____ State: _____ ZIP Code: _____

PRIMARY INSURANCE

Primary Medical Insurance: _____

Insured Party: Self Spouse Parent Other Sex: M F Date of Birth: _____

ID No. / Social Security No.: _____ Group Plan No.: _____

Name (if other than self): _____

SECONDARY INSURANCE

Primary Medical Insurance: _____

Insured Party: Self Spouse Parent Other Sex: M F Date of Birth: _____

ID No. / Social Security No.: _____ Group Plan No.: _____

Name (if other than self): _____

I authorize the release of any medical information necessary to process claims pertinent to my care with the above physician and authorize my insurance company to make payment directly to my physician.

Date: _____ Signature: _____



1029 Kapahulu Ave., #502
 Honolulu, Hawaii 96816
 Telephone (808) 782-1861
 Fax (808) 218-7830

Drs. Carlton Yuen & Jason Tokunaga

**OFFICE POLICY ON PRIVACY PRACTICES
 PATIENT DISCLOSURE**

In accordance with the American Medical Association Code of Ethics, I believe that the patient-physician relationship is based on trust and the confidentiality of communication. The free and uninhibited disclosures of personal information within this relationship are the cornerstone of good medical care.

The privacy of your medical records is of the utmost importance to my staff and me. I have therefore taken measures to ensure that your medical records receive the highest level of confidentiality and security. This office adheres to the following procedures to ensure protection of your private medical records.

- My office staff has received education and training regarding the use and handling of patients' protected health information
- Your records are secured in a locked facility during non-office hours
- Access to office keys are limited to the staff of this facility, building management and cleaning staff
- Access to electronic information is secured via passwords
- Your private medical information is only released as required or permitted by state and federal law

In order to continue to provide personalized service to our patients and function effectively:

- We utilize outside services, such as transcriptionists or consultants
- Your name, status and location may be revealed within the office setting
- Laboratory, test results, and clinical notes may be shared with other physician(s) participating in your medical care.
- Confidentiality can be expanded to exclude information issued to insurance companies by choosing to not use any health insurance or third party payment as payment for services. In this scenario any and all health care services rendered, we will submit your charges to your health insurance, other third party, or employ the services of a collection agency
- If you request copies of your records, there will be a charge of \$1.00 per page

I have read, understand and agree to the privacy practices of Drs. Carlton Yuen & Jason Tokunaga and have received a copy of my patient rights and responsibilities.

Patient Signature

Date

Print Patient Name

Date of Birth



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Drs. Carlton Yuen & Jason Tokunaga

**CONSENT TO RELEASE
PROTECTED HEALTH INFORMATION PURSUANT TO H.R.S. 323C**

Authorization is hereby given to Drs. Carlton Yuen & Jason Tokunaga to disclose and be furnished any and all health care information including medical records, reports, x-rays, diagnostic test results, bills, and payment records with respect to medical treatment or qualified healthcare operations provided to:

- a) Any health insurance plan or company that provides insurance coverage for me for the purpose of payment of charges;
- b) Any insurance company that provides liability insurance coverage for Drs. Carlton Yuen & Jason Tokunaga for the purpose of evaluating the treatment rendered to me;
- c) To leave messages regarding my appointments of health information on my answering machine / voicemail

This authorization also gives Drs. Carlton Yuen & Jason Tokunaga permission to speak to the following spouse, family member, relative or friend regarding my medical information and treatment:

<u>Name</u>	<u>Relationship</u>	<u>Name</u>	<u>Relationship</u>
_____	_____	_____	_____
_____	_____	_____	_____

This authorization shall cover the period of time from my first visit to my last visit.

I understand that I can revoke this authorization at any time.

This authorization shall end two years after the date of my last visit.

I release Drs. Carlton Yuen & Jason Tokunaga from all legal responsibility that may arise from this authorization.

Patient Signature

Date

Print Patient Name

Date of Birth

Signature of Parent or Legal Guardian if Minor



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Drs. Carlton Yuen & Jason Tokunaga

NEW PATIENT EYE EXAM

Thank you for choosing Aloha Vision Consultants, Inc. The eye examination includes the following: External exam, Slit lamp exam, Intraocular pressure measurement, and Fundoscopic examination. Other tests not listed may be performed depending on your needs. While diagnostic tests to further evaluate your eyes are typically covered by insurance, in instances where diagnostic tests are not covered by your insurance company it is your financial responsibility. These include: refraction, external photos, fundus photos, OCT, topography, visual fields, etc. If you have questions regarding these tests please do not hesitate to ask.

Your fundoscopic examination will include a dilated exam, unless contraindicated or you do not wish to be dilated today. **If you do not wish to be dilated today please inform us and we will reschedule dilated examination for another day.** Dilation typically lasts 4 to 6 hours but may last longer. You may experience difficulty driving, reading, walking, and blurry vision.

You may be placed on medications including eye drops or pills. These medications in very rare incidences may cause: allergic reactions, loss of vision, blindness, infections of the eye, glaucoma, cataracts, tingling, fever, vomiting, Steven’s Johnson Syndrome, rashes, numbness, tingling, fever, vomiting, heart failure, shortness of breath, exacerbation of asthma, deposits on eyes, infection, pain, death. If you experience an adverse reaction to any medications prescribed by our physicians, stop the medication immediately and call us.

If you have any questions regarding the above please do no hesitate to ask our physicians.

 Patient Signature/ Guardian

 Date

 Printed Name



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Drs. Carlton Yuen / Jason Tokunaga

Patient Medical History

List medications you are currently taking: (Including Aspirin & Vitamins)

- 1. _____ 2. _____ 3. _____
- 4. _____ 5. _____ 6. _____
- 7. _____ 8. _____ 9. _____
- 10. _____ 11. _____ 12. _____

Allergies:

Surgeries:

Do you smoke? (Yes / No) (Social / Daily / Weekends)

Do you drink alcohol? (Yes– Social / Daily / Weekends or No)

PATIENT AND FAMILY HISTORY:

	Patient	Family
Cataract	YES / NO	YES / NO
Glaucoma	YES / NO	YES / NO
Macular Degeneration	YES / NO	YES / NO
Retinal Detachment	YES / NO	YES / NO
Arthritis	YES / NO	YES / NO
Asthma	YES / NO	YES / NO
Bleeding Disorders	YES / NO	YES / NO
Cancer	YES / NO	YES / NO
Depression / Psychosis	YES / NO	YES / NO
Diabetes Type 1 or Type 2	YES / NO	YES / NO
Gastrointestinal Problems	YES / NO	YES / NO
Headache	YES / NO	YES / NO
Heart Problems	YES / NO	YES / NO
High Blood Pressure	YES / NO	YES / NO
High Cholesterol	YES / NO	YES / NO
Skin Problems	YES / NO	YES / NO
Stroke	YES / NO	YES / NO
Thyroid Problems	YES / NO	YES / NO
Trouble Breathing	YES / NO	YES / NO
Urinary Problems	YES / NO	YES / NO