



JENKINS EYE CARE

615 Piikoi Suite 205 Honolulu, HI 96814 ~ 808-591-9911 ~ toll free 855-522-2020 ~ www.jenkinseyecare.com

PATIENT INFORMATION

ACCOUNT NUMBER _____

Patient Name: _____ Date: _____

Address: _____

Phone: _____ Cell: _____ E-Mail _____

Work Number: _____

Date of Birth: _____ Female Male Retired: Yes/No Student Status: FT/PT

SSN _____ Marital Status: Single Married Divorced Widow

Occupation: _____

Referred By: _____ Do you have a facebook account: Yes/No

How did you hear about us? Radio Internet Google Friend Family

Other: _____

INSURANCE INFORMATION

Primary Insurance: _____ Subscriber's Name: _____

Subscriber's DOB: _____ Policy Number: _____

Subscriber's Sex: M F

Employment Status: FT/PT Employer: _____

Secondary Insurance: _____ Subscriber's Name: _____

Subscriber's DOB: _____ Policy Number: _____

Subscriber's Sex: M F

Employment Status: FT/PT Employer: _____

Tertiary Insurance: _____ Subscriber's Name: _____

Subscriber's DOB: _____ Policy Number: _____

Subscriber's Sex: M F

Employment Status: FT/PT Employer: _____

IN CASE OF EMERGENCY PLEASE CONTACT

Name: _____ Relationship: _____
Phone: _____ Cell: _____

(IF DIFFERENT FROM PATIENT INFORMATION)

Name: _____ Phone: _____
Address: _____ City, State, Zip _____
Date of Birth: _____ Male Female Social Security #: _____
Employer: _____ Occupation: _____ Student Status: FT/PT
Work Address: _____
Email: _____

I hereby authorize Tyrie Lee Jenkins, 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 Tyrie Lee Jenkins, M.D. 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.

Patient or Legal Guardian: _____ Date: _____
(signature)

PATIENT MEDICAL HISTORY

Name of Patient: _____ Date: _____

Internal Medicine Doctor: _____ Last Seen: _____

Optometrist/Ophthalmologist: _____ Last Seen: _____

Do you wear glasses? Yes/No How old are they _____ *Single Multifocal Readers*

Do you wear Contact Lenses? Yes/No Hard/Soft Brand: _____ Power: _____ BC: _____ Diameter: _____

List medications you are currently taking: (including aspirin & Vitamins)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

Allergies: _____

Eye surgeries/Procedures (*type & date*)

Other surgeries (*type & date*)

Do you Smoke: Yes/No Social/Daily

Do you drink alcohol? Yes/No Social/Daily

PATIENT AND FAMILY HISTORY

Arthritis	Patient: Yes/No	Family: Yes/No
Asthma	Patient: Yes/No	Family: Yes/No
Lazy Eye	Patient: Yes/No	Family: Yes/No
Cancer	Patient: Yes/No	Family: Yes/No
Cholesterol	Patient: Yes/No	Family: Yes/No
Diabetes <i>Type I or II</i>	Patient: Yes/No	Family: Yes/No
Gastrointestinal	Patient: Yes/No	Family: Yes/No
Glaucoma	Patient: Yes/No	Family: Yes/No
Head and Neck Problems	Patient: Yes/No	Family: Yes/No
Heart Problems	Patient: Yes/No	Family: Yes/No
Heme/Lymph Bleeding	Patient: Yes/No	Family: Yes/No
High Blood Pressure	Patient: Yes/No	Family: Yes/No
Lazy Eye	Patient: Yes/No	Family: Yes/No
Lungs/Respiratory	Patient: Yes/No	Family: Yes/No
Macular Degeneration	Patient: Yes/No	Family: Yes/No
Neurological Problems	Patient: Yes/No	Family: Yes/No
Psychosocial	Patient: Yes/No	Family: Yes/No
Retinal Detachment	Patient: Yes/No	Family: Yes/No
Skin Problems	Patient: Yes/No	Family: Yes/No
Thyroid	Patient: Yes/No	Family: Yes/No
Urinary Problems	Patient: Yes/No	Family: Yes/No

Other: _____

Dear Patient:

Your safety is important to us

We would like you to take a few minutes to read and understand the following important information about eye examinations and some of the eye drops that are used during your eye examinations.

Once your eyes have been dilated, the following may occur for a period of time:

- Light Sensitivity
- Glare
- Blurred Vision
- Difficulty walking due to blurred vision
- Difficulty driving due to blurred vision

Wearing dark glasses after dilation helps to ease some of these challenges, so.....

PLEASE BRING DARK GLASSES WITH YOU TO ALL OF YOUR EYE EXAMS

It is strongly recommended that you avoid driving or operating dangerous machinery, and be extremely careful walking so that you do not injure yourself. We also suggest that you arrange for transportation home after a dilated eye exam.

PLEASE CALL OUR OFFICE IMMEDIATELY AT 591-9911, IF YOU SHOULD EXPERIENCE ANY OF THE FOLLOWING AFTER YOUR DILATED EXAM WITH US: Eye Pain, Headaches, and/or loss of vision

I have been informed, my questions have been answered and I understand the vision and safety problems associated with dilation. I will wear sun glasses following dilation and have arranged for transportation assistance.

This notice covers the period of time from my first visit to my last visit.

(Patient Signature)

(Date)

(Print Name)

ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

TYRIE LEE JENKINS, M.D. INC

This authorization also gives Tyrie lee Jenkins, M.D. Inc. permission to leave messages regarding my appointments of health information on my answering aching/voicemail.

Tyrie Lee Jenkins, M.D. Inc. has my permission to speak to the following spouse, family member, relative, or friend regarding my medical information and treatment:

(Name) (Relationship)

(Name) (Relationship)

I authorize the following persons (or class of person) to make the authorized use and/or disclosure of my protected health information:

(Name) (Relationship)

(Name) (Relationship)

I hereby acknowledge that I have received and reviewed a copy of the Notice of Uses and Disclosure of Protected Health Information from Tyrie Lee Jenkins, M.D. Inc., that details their Privacy Policy as required by the Health Information Portability and Accountability Act of 1996 ("HIPPA")

(Signature) (Date)

(Print Name)

(Name of Personal Representative) (Relationship to Patient)

Office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign _____ (patient initial)
- Communication barrier prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Patient is blind
- Other (please specify) _____