KAUA'I
EYE INSTITUTE

808-245-8765
front@kauaieye.com
www.kauaieye.com

PATIENT INFORMATION Today's Date:_____

Last Name: _____First Name:_____M or F

Name Preference:_____DOB:_____SSN: _____

Mailing Address:_____City_____State_____Zip_____

Phone Number:_____Email Address:_____

Primary Care Physician:_____ Optometrist:_____ Height: _____Weight:_____

Reason for Today's exam_____

(You do not need to complete section below if you have already entered all pertinent information into your patient portal on kauaieye.ema.md)

Past medical history (list major medical problems, diagnoses): _____

_____

_____

_____

Past surgical history (list any major surgeries): _____

_____

Past ocular history (check):

☐ Cataract ☐ Glaucoma ☐ Pterygium ☐ Retinal Problems ☐ Macular degeneration ☐ Dry eyes ☐ Ocular allergies

☐ Other (list): _____

☐ Eye surgery (e.g. LASIK, cataract): _____

Preferred Pharmacy (Name, City): _____

Medications (list all medications being taken): _____

_____

_____☐ Check if you agree to allow us to obtain list of meds from pharmacy

Allergies (name medication and type of reaction): _____

_____

Family history (check and write name of family member):

☐ Cataract _____ ☐ Glaucoma _____ ☐ Retinal Problems _____☐ Macular degeneration _____

☐ Cancer _____ ☐ Crossed eyes _____ ☐ Other (list): _____

Social history:

Occupation (circle one): employed / self-employed / retired / other Job title: _____

Alcohol use (check): ☐ None ☐ Occasional (<1 drink/day) ☐ Daily (1-2 drinks/day) ☐ Moderate (3+ drinks/day)

Smoking (check): ☐ Never ☐ Former smoker (___ packs/day x ___ yrs) ☐ Current smoker (___ packs/day x ___ yrs)

Emergency contact: Name: _____ Phone: _____ Relation to pt: _____

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4368 Kukui Grove St.
Ste:102
Lihue, HI 96766
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808-245-8816 (fax)
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Patient Authorization Form

Date: _____

Patient Name: _____

Date of Birth: _____

Many of our patients allow family members such as their spouse, significant other, partner or children to call and request the result of tests, procedures and financial information. Under the requirements for HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, except where we have already made disclosures in reliance on your prior consent.

I authorize Kauai Eye Institute to release my medical and any information requested to the following individuals:

Names	**Relationship to Patient**
_____	_____
_____	_____
_____	_____
_____	_____

Patient Signature: _____ Date: _____

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Privacy Policy

How We Collect Information About You
Kauai Eye Institute (KEI) and its employees collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voicemails, and from the submission of applications that are either required by law or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information:
Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voicemails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence. We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that are considered patient confidential, restricted by law, or specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information:
Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between KEI and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to verify your medical information is accurate and determine the type of medical supplies or health care services you need. This is including, but not limited to, or to obtain or purchase any type of medical supplies, devices, medications, or insurance.

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect:
We do not use cookies on our website to collect date from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page (www.kauaieye.com) that simply records the number of visitors and no other data. We do use some affiliate programs that may or may not capture traffic date through our site. To avoid potential data capture that you visited a diabetes website simply do not click on any of our outside affiliate links.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources:
Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of KEI. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addres phone numbers, contact information, last names or uniquely identifiable names) will be used without the client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

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HIPAA Statement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: 1) conduct, plan, and direct my treatment and follow up among the multiple health care providers who may be involved in that treatment directly or indirectly; 2) obtain payment from third party payers; 3) conduct normal healthcare operations such as quality assessments and physical certifications.

I have been informed of your Privacy Policy, which contains a more complete description of the uses and disclosures of my health information. I have been given the right to review such Privacy Policy prior to signing this consent. I understand that this organization has the right to change its Privacy Policy from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Privacy Policy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time to the extent that you have taken action relying on this consent.

Signature _____ Date : _____