Patient Registration and History
Exam

Pearlridge, Uptown: 98-1005 Moanalua Rd. #876 ♦ Aiea, HI 96701
Ward Centre: 1200 Ala Moana Blvd. #255 ♦ Honolulu, HI 96814

Patient Name: ______ Male □ Female □

Address: ______ City: ______ State/Zip Code: ______

Email: ______ Home Tel #: ______ Cell #: ______

SS #: ______ Birth date: ______

Employer: ______ Work Tel #: ______ Occupation: ______

Referred By: □ Walk-in □ Family/Friend □ Ad

Do you work on a computer? **Y** **N**
If YES, number of hours per day?

Do you wear glasses? **Y** **N**
If YES, for Distance Near Both
If YES, how old are they?

Do you have contact lenses? **Y** **N**
If NO, are you interested in contact lenses? **Y** **N**

If YES, what type of contact lenses are you wearing?

1. Soft - or - Gas Permeable
2. Daily Disposable - or - Standard
3. Astigmatism - or – Spherical
4. Distance only - or - Monovision Bifocal

If YES, what is the name of contact lenses you are wearing?

Have you had refractive surgery? **Y** **N**
If NO, are you interested in the procedure? **Y** **N**

Insurance and Payment Authorization

**Tricare: please provide Benefits #, back side of Military ID*
**VSP: please provide subscriber's full Social Security #*

Primary Insurance / Member ID:
Medical: ______
Vision: ______

Relationship: Self Spouse Child Other
Subscriber's Name DOB:

Secondary Insurance / Member ID:
Medical: ______
Vision: ______

Relationship: Self Spouse Child Other
Subscriber's Name DOB:

I request that payment of authorized insurance benefits be made on my behalf to Dr. Michael VanLangeveld and Associates, LLC dba InSpecs Eyewear. I authorize the release of information necessary to process claims. I permit my signature to be kept on file for future visits and insurance filings.

Due to the varying nature of vision and health insurance company plans, there may be additional fees or eligibility denials that my insurance dictates at the time of filing my insurance by Dr. Michael VanLangeveld and Associates, LLC dba InSpecs Eyewear . I understand and agree that regardless of my insurance benefits, I (or my guarantor) am responsible to pay for the balance on my account for all professional services and materials provided. I understand that if payment is not made in a timely manner, I may incur a 1.5% late fee on all balances of 60 days or more unless financial arrangements are made.

______
Patient Name

______
Signature of Responsible Party

______
Relationship to Patient Date

Purpose of Today's Visit?

EYES

Blurred Vision at Distance	Y	Excess Tearing/Watering	Y	Mucous Discharge	Y
Blurred Vision at Near	Y	Flashes of Light	Y	Redness	Y
Burning	Y	Floaters/Spots in Vision	Y	Sandy or Gritty feeling	Y
Eye pain or Soreness	Y	Foreign Body Sensation	Y	Tired Eyes	Y
Double Vision	Y	Glare/Light Sensitivity	Y	Other:	Y
Dryness	Y	Itching	Y	Explain	

Please list all current medications:

Please list any drug allergies:

SOCIAL HISTORY

This information is kept strictly confidential.

Do you smoke Cigarettes/Tobacco?	Y
Do you drink Alcohol?	Y
Do you use any other substances/recreational drugs?	Y

FAMILY HEALTH HISTORY

Please circle all that apply and state which relative:

Ocular:		Relative (Mother, Father, Sibling, Maternal/Paternal Grandparent)
Blindness	Y	
Cataracts	Y	
Glaucoma	Y	
Lazy/Turned Eye	Y	
Macular Degeneration	Y	
Retinal Detachment	Y	
Other eye conditions:	Y	

Systemic:		
Arthritis	Y	
Cancer	Y	
Diabetes	Y	
Headaches/Migraines	Y	
Heart Disease	Y	
High Blood Pressure	Y	
Thyroid	Y	
Other health conditions:	Y	

REVIEW OF SYSTEMS

Do you currently, or have you ever had problems in the following areas?

Allergy	Y
Cardiovascular	
Diabetes	Y
High Blood Pressure	Y
Vascular Disease	Y
Heart Condition	Y
Constitutional	
Fever	Y
Weight loss/gain	Y
Endocrine	
Thyroid/other glands	Y
Gastrointestinal	
Diarrhea	Y
Constipation	Y
Genitourinary	
Kidney	Y
Bladder	Y
Genitals	Y
Ear, Nose, Mouth, Throat	
Allergies	Y
Hay Fever	Y
Sinus Congestion	Y
Hematological/Lymphatic	
Anemia	Y
Bleeding Problems	Y
Immunological	Y
Integumentary (Skin)	Y
Musculoskeletal: Bones/Joints/Muscles	
Rheumatoid Arthritis	Y
Muscle Pain	Y
Joint Pain	Y
Neurological	
Headaches	Y
Migraines	Y
Seizures	Y
Psychiatric	Y
Respiratory	
Asthma	Y
Emphysema	Y
Chronic Bronchitis	Y

Dr. Michael VanLangeveld

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INSURANCE AND PATIENT BILLING

New Patients – If you want Dr. Michael VanLangeveld to bill your insurance card, you are required to provide your medical and vision insurance card(s) for any primary and secondary plans at the time of service. If you have no insurance or do not wish for us to bill your insurance, you will be required to pay in full at the time of service.

Established Patients – You will need to bring your current medical and vision insurance card(s) to each visit so that our staff can verify current insurance information for billing the services you receive. Established patients are also required to complete an updated registration form to confirm billing information on an annual basis or at any time there is a change in billing information. If you have no insurance, or do not wish for us to bill your insurance, you will be required to pay in full at the time of service.

MEDICAL INSURANCE VERSUS VISION PLANS

Routine vision plans, or vision benefit plans, only cover wellness eye exams in which there are absolutely no problems noted other than the need for glasses or contact lenses. Examples include: Eyemed, Spectera, and VSP.

Major medical insurance covers your visits to our office when problems are diagnosed or found (whether or not you need glasses or contact lenses). The findings that trigger major medical processing are many and varied. Relatively minor problems such as dryness, fluctuating vision, floaters, headaches, excessive tearing, and itchy eyes all constitute routine vision care. More significant findings such as red eyes, eye pain, injuries, infections, cataracts, glaucoma, diabetes, high blood pressure, and retinal problems also do not constitute routine vision care. Accordingly, such visits are processed through your major medical insurance (not your routine vision plan) and are subject to those co-pays and deductibles.

CO-PAYS AND DEDUCTIBLES

All co-pays and deductibles vary widely from one company to another and must be paid at the time of service. This arrangement is part of your contract with your insurance company. We do not set the co-pays or deductible amounts.Please remember that we are your advocates in this process and want to make the insurance paperwork process as simple aspossible. If you have any questions, please do not hesitate to ask.

RECEIPT OF PRIVACY NOTICE

I hereby acknowledge that I am aware of the HIPAA Privacy Notice that explains how my health information will be handled in various situations. I further understand that:

- The HIPAA Policy is displayed and available at all times during regular business hours.
- I am able to request another copy of this notice.
- I may discuss or ask any questions I may have regarding the privacy notice with my provider.
- Federal law requires that a signed copy of this form be retained with my electronic Personal Health Information file.

Federal regulation requires that we give our patients or their authorized representatives our Notice before signing this acknowledgment.

RELEASE OF INFORMATION

I hereby authorize Dr. Michael VanLangeveld and Associates, LLC dba InSpecs Eyewear to release to my insurance company and/or associated professionals any information from my medical record, which may be necessary to determine benefits payable under my policy.

ASSIGNMENT OF BENEFITS

I authorize Dr. Michael VanLangeveld and Associates, LLC dba InSpecs Eyewear to act as my agent in obtaining payment from my insurance company, and authorize payment of said benefits directly to Dr. Michael VanLangeveld and Associates, LLC dba InSpecs Eyewear. I understand I am financially responsible for any charges not covered by my insurance and/or settled by my claim.

My signature below acknowledges that I have read and understand the Financial & Filing Insurance Policy and Dr. Michael VanLangeveld and Associates, LLC dba InSpecs Eyewear Notice of Privacy Practices - Health Insurance Portability and Accountability Act (HIPAA).

This authorization will remain on file until written notice has been submitted to Dr. Michael VanLangeveld and Associates, LLC dba InSpecs Eyewear.

____
Patient Name

____
Signature of Responsible Party

____
Relationship to Patient Date