Alan R. Faulkner, MD
Leslie Garay, MD
Kathryn Mau, OD

ALOHA LASER VISION
People Of Vision

1100 Ward Ave Suite 1000
Honolulu, HI 96814
Phone 808-792-3937

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Street Address: _____ **Zip, City, State:** _____

Are you interested in advanced skin care and/or treatments? [ ] YES [ ] NO

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Marital Status: [ ] Single [ ] Married [ ] Widowed

Date of Birth: _____

Social Security #: _____

Race: [ ] American Indian or Alaskan Native [ ] Asian [ ] Black or African American [ ] Native Hawaiian/Other Pacific Islander
[ ] White [ ] Other Race [ ] Declined to Specify

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Declined to Specify

Preferred Language: [ ] English [ ] Japanese [ ] Chinese [ ] Tagalog [ ] Spanish [ ] Other_____

Emergency Contact Information:

Name: _____

Relationship: _____

Phone #: _____

Primary Care Physician: _____

How were you referred to our office?

[ ] Doctor: _____

[ ] Long Time Patient [ ] Patent: _____

Social Media: [ ] Facebook [ ] Yelp [ ] Google [ ] Instagram

Other: [ ] Insurance Listing [ ] Magazine [ ] TV [ ] Radio

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE CARRIER: _____

SUBSCRIBER ID #: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DOB: _____

RELATIONSHIP TO SUBSCRIBER:
[ ] SELF [ ] SPOUSE [ ] CHILD [ ] OTHER

SECONDARY INSURANCE

INSURANCE CARRIER: _____

SUBSCRIBER ID #: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DOB: _____

RELATIONSHIP TO SUBSCRIBER:
[ ] SELF [ ] SPOUSE [ ] CHILD [ ] OTHER

OTHER INSURANCE INFORMATION: _____

PLEASE READ & SIGN:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to Aloha Laser Vision, LLC. I understand that my insurance will be billed. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

SIGNATURE: _____ **DATE:** _____

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PATIENT PRIVACY CONSENT FORM

PATIENT NAME: _____ ***DOB:*** _____

The Practice provides the top portion of this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment of health care operations. We are not required to agree to this restriction, but if we do, we shall honor this agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

Signature: _____ Date: _____

_____ / _____ _____
Patient Representative Representative Signature Date

REPRODUCTION RIGHTS

I HEREBY GRANT TO **ALOHA LASER VISION**, including its employees, agents, assigns, or other third party as the aforementioned business may authorize on its behalf, the nonexclusive rights to **photograph me, make recordings of my voice and make combined audio visual recording of me and my voice.**

I CONSENT TO THE USE OF THESE RECORDINGS BY ALOHA LASER VISION for educational materials, publications, websites, social media, and other consistent purposes. I hereby assign the transfer to Aloha Laser Vision all rights to these audio and visual recordings and all benefits and advantages to be derived from these. Editing, publication, distribution, broadcast and use of this material shall be at the sole discretion of Aloha Laser Vision. It is possible that individuals may find your image/video/story helpful and wish to link to it from their own personal websites. Owners of other personal and corporate websites do not need to ask our permission to link our website or Facebook page. As a result, you may find your story linked from other sites on the web. In addition, as our site is crawled regularly by internet search engines, your information may be found when searching the web via Google or other reputable search engines.

Patients' identity, as indicated below MAY be included in the resources as developed and published in print, electronic, or digital format including any authorized website. Consent takes effect when this agreement is signed.

☐ First & Last Name ☐ First Name Only ☐ neither First or Last Name

☐ I DO NOT CONSENT TO THESE RIGHTS

Signature: _____ Date: _____

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Name: _____ **Date:** _____

Occupation: _____ **Age:** ☐18-29 ☐30-49 ☐50-64 ☐65+

☐**Male** ☐**Female**

-If so are you **currently** or have you **recently** been breastfeeding? ☐ Yes ☐ No

-If **yes**, has it been **more than** 1 month since you **last** breastfed? ☐ Yes ☐ No

1. **Do you wear contact lenses?**

   ☐Yes ☐No

   if yes, when is the last time you have worn your contact lenses? _____

   Type of contacts:

   ☐ Soft ☐ Toric Soft (for astigmatism) ☐RGP/Hard ☐Other _____

2. **Do you wear glasses?**

   ☐ Yes ☐ No

   Type of glasses:

   ☐ Distance ☐ Reading ☐ Progressive/Bifocal ☐Other _____

3. **Do you have a history of:**

   ☐Keratoconus ☐Glaucoma ☐Keloid Former ☐High Blood Pressure

   ☐Thyroid Condition ☐Herpes Simplex ☐Diabetes ☐Rheumatoid Arthritis /Collagen Vascular Disease

   ☐Former Eye Surgeries: _____ ☐ Past Eye Conditions: _____

4. **Do you take or have you ever taken:** ☐Amiodarone ☐Accutane ☐Imitrex

5. **Is this your first vision correction consultation?** ☐ Yes ☐ No

6. **Has anyone ever told you that would be a good candidate for the LASIK procedure?** ☐Yes ☐No

7. **If we determine that you are a candidate, when do you plan on having LASIK or refractive surgery?**

   _____

8. **How long have you been considering vision correction?** _____

9. **Do you have any fears regarding vision correction?** _____

10. **What activities do you participate in?** _____

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11. **Other than financial arrangements is there anything that has prevented you from proceeding with a vision correction procedure?** ☐ Yes ☐ No

    Please explain: _____

12. **Do you know any friends or family who have had a vision correction procedure?** ☐ Yes ☐ No

13. **If you could function throughout your day without the dependence on contacts or glasses would you consider the procedure a success?** ☐ Yes ☐ No

14. **Are you interested in learning about our various financing options?** ☐ Yes ☐ No

15. **What social media sites do you use regularly?** _____

16. **What radio stations do you listen to regularly?** _____

17. **Which newspapers do you read regularly?** _____

18. **What TV stations do you watch regularly?** _____

19. **What is the best way to contact you?** _____

20. **How did you hear about us?** _____

21. **When was your last eye exam?** _____

22. **What is it about your glasses/contacts that currently prevents you from enjoying everyday living?**

    _____

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We are located in the **FIRST INSURANCE CENTER** on the corner of Ward Ave & Beretania St

You may enter the parking garage from BERETANIA ST ONLY

Hotel St. garage entrance is no longer open to the public

You will need to drive up to P3 OR HIGHER for parking

From the parking garage you will need to catch the elevator down to the lobby, then transfer elevator up to the 10th floor. **Our clinic is located on the 10th FLOOR SUITE 1000**

Please note that you are **NOT** allowed to make a left turn from Ward Ave on to Beretania St

Parking is partially validated down to $1 per half hour.

*Please refer to **www.alohalaservision.com** for further driving directions*