Dennis I. Maehara, M.D.
Jeffrey R. Maehara, M.D.
1441 Kapiolani Blvd. Suite 1419
Honolulu, HI 96814

PATIENT INFORMATION

Name:______________________________Date:_______________ Referred by:________________
Birth date:______________________________Social Security #:___________________________
Address:___________________________City:_________________State:______ZIP:___________
Home #:______________________Work #:______________________Other #:________________
Patient Employer:____
Spouse/Parent Employer:_____________________________________Phone #:_______________
Medical Insurance (Primary):____
Member #:___________________________________Subscriber:____________________________
Subscriber D.O.B.:____________________________Subscriber's SS#:______________________
Medical Insurance (Secondary):____
Member #:___________________________________Subscriber:____________________________
Subscriber D.O.B.:____________________________Subscriber's SS#:______________________
In case of emergency (someone NOT living with you) contact: Name:___________________________
Address:____________________ City:__________State:____ZIP:________Phone #:___________
Person responsible for bill:__________________________________Relationship:_______________
Patient/Responsible party signature:____

Dennis I Maehara M.D., Inc.
Jeffrey R. Maehara M.D.
1441 Kapiolani Blvd Suite #1419
Honolulu, HI 96814

I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits or insurance benefits on services and drugs to the party who accepts assignment.

Signed ______________________________

Date ________________________________

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF USES AND DISCLOSURES
OF PROTECTED HEALTH INFORMATION
FOR
Dennis I. Maehara, M.D.
Jeffrey Maehara, M.D.

I have read the Notice of Uses and Disclosures of Protected Health Information (the "Notice") that is posted in your office. I was informed that I may also obtain a printed copy of the Notice from your receptionist. I hereby acknowledge that I received from Maehara Eye Clinic a copy of the Notice.

____

Print Your Name

____

Signed

____

Date

MEDICAL HISTORY QUESTIONNAIRE

NAME DATE

DATE OF BIRTH ____________________ DATE OF LAST EYE EXAM ____________

REASON FOR YOUR OFFICE VISIT? ____________________

LIST OF ANY MEDICATIONS YOU CURRENTLY TAKE (PRESCIPTION AND OVER-THE-COUNTER): ____________________

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO
IF YES, LIST THE MEDICATIONS: ____________________

LIST ALL MAJOR ILLNESSES (GLAUCOMA, DIABETES, HIGH BLOOD PRESSURE, HEART ATTACK, ETC.) OR INJURIES (CONCUSSION, ETC.): ____________________

LIST ANY SURGERIES YOU HAVE HAD (CATARACT, TONSILLECTOMY, APPENDECTOMY):
____

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS? IF YES, PLEASE PROVIDE INFORMATION.

	YES	NO	DETAILS
EYES			
LOSS OF VISION			
BLURRED VISION			
FLUCTUATING VISION			
DISTORTED VISION (HALOS)			
GLARE OR LIGHT SENSITIVITY			
LOSS OF SIDE VISION			
DRYNESS			
MUCOUS DISCHARGE			
REDNESS			
SANDY OR GRITTY FEELING			
ITCHING			
BURNING			
FOREIGN BODY SENSATION			
EXCESS TEARING OR WATERING			
EYE PAIN OR SORENESS			
INFECTION OF EYE OR LID			
TIRED EYES			
CROSSED EYES, LAZY EYE			
DROOPING EYELID			
GENERAL/CONSTITUTIONAL (fever, weight loss, Other)			
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, Dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, etc.)			

GASTROINTESTINAL (stomach upset, diarrhea, Constipation, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
MUSCLES, BONES JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hyperthyroid, etc.)			
BLOOD/LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)			

FAMILY HISTORY

M-mother F-father S-sibling GP-grandparent

DISEASE	**YES**	**NO**	**RELATIONSHIP TO PATIENT**
BLINDNESS			
GLAUCOMA			
ARTHRITIS			
CANCER			
DIABETES			
HEART DISEASE OR HIGH BP			
KIDNEY DISEASE			
LUPUS			
STROKE			
THYROID DISEASE			
OTHER			

SOCIAL HISTORY

Current occupation: ____________________

Education (high school, vocational school, college degree): ____________________

Marital status (married, divorced, single, widowed): ____________________

Living arrangements (who do you live with) ____________________

Do you drive? -------------------------------------YES NO

Do you have visual difficulty when driving?----YES NO

Do you have problems with night vision?-------YES NO

Have you ever tried to wear contacts?-----------YES NO

Do you currently wear contact lenses?-----------YES NO If yes how long?

Do you currently wear glasses?-------------------YES NO If yes, how long have you had your currently Prescription? ____________

Have you ever had a blood transfusion?---------YES NO

Do you drink alcohol?--------YES NO If yes: occasional 1/day 2-3/day 4+/day

Do you smoke?-----------------YES NO If yes: occasional ½ pack /day 1 pack/day 1+ pack/day

Signature ____________________ Date ____________

Maehara Eye Clinic

NOTICE OF THE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by federal law to maintain the privacy of your Protected Health Information, and to provide you with notice of our legal duties and privacy practices regarding Protected Health Information. "Protected Health Information" is information that we keep in electronic, paper or other form, including demographic information collected from you and is created or received by us and relates to your past, present, or future physical or mental health or condition, the provision of health care services to you, or the past, present, or future payment for the health care services we deliver to you, and that identifies you or which we reasonably believe can be used to identify you.

We are required by federal law to comply with the terms of this Notice. We reserve the right to make changes in our privacy practices regarding your Protected Health Information. If we change our privacy practices, that change will apply to all Protected Health Information that we maintain about you. However, before we change our privacy practices, we will provide you with written notice of any changes.

We may use and disclose your Protected Health Information for a variety of purposes. For example:

1. Treatment: We may disclose your Protected Health Information to another physician, such as a specialist, to whom we refer you for medical treatment.

2. Health Care Operations: We may disclose your Protected Health Information to a health plan, managed care plan, individual practice association or to a management services organization that analyzes our delivery of medical services to evaluate our health care quality management, case management or professional competence. We may also provide your Protected Health Information to other health care providers, such as laboratories or ambulance companies, for purposes of their health care operations.

3. Payment: We may disclose your Protected Health Information to obtain payments. Disclosures for "payment" include: (a) disclosure to a health plan to determine your eligibility or coverage under the plan; (b) disclosures to a health plan to obtain reimbursement for delivering medical services to you; (c) disclosures to billing services or collection agencies; (d) disclosures for utilization management and determinations of whether the medical services we deliver to you are necessary or appropriate; or (e) disclosures to determine whether the amount we charge you for medical services are justifiable.

4. Reminders and Treatment Alternatives: We may contact you to provide you with appointment reminders or information about medical treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your Protected Health Information in connection with treatment, payment, or

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health care operations if we deliver health care products or services to you based on the orders of another health care provider, and we report the diagnosis or results associated with the health care services directly to another health care provider, who provides the products or reports to you. We may use or disclose your Protected Health Information that was created or received in emergency treatment situations, to carry out treatment, payment, or health care operations if we attempt to obtain your consent as soon as reasonably practicable after the delivery of such treatment.

We may disclose your Protected Health Information without your authorization in the following circumstances: (a) for public health activities, such as controlling communicable diseases, reporting child abuse or neglect, to monitor or evaluate the quality, safety or effectiveness of FDA-related products or services; (b) for reporting victims of abuse, neglect or domestic violence; (c) for health oversight activities, such as overseeing government benefit programs; (d) in response to judicial or administrative orders, such as subpoenas; (e) for law enforcement purposes, such as mandatory reporting of certain types of wounds, or identifying or locating individuals; (f) for certain research purposes; (g) to avert a serious threat to the health or safety of an individual or the general public; and (h) for selected governmental functions, such as national security. In each of these situations we will keep records that explain our attempt to obtain your consent and the reason why consent was not obtained.

We are required to disclose your Protected Health Information: (a) to you upon your request; and (b) to the U.S. Department of Health and Human Services ("DHHS") when DHHS investigates to determine whether we are complying with federal law.

We may disclose your name, your location in our facility, your general condition and your religious affiliation, if any, in our facilities directory, unless you object verbally or in writing.

In all other circumstances we must obtain your authorization to use or disclose your Protected Health Information. You will be required to sign an authorization form which permits us to use and disclose your Protected Health Information for certain purposes, and we may not condition the delivery of medical treatment to you on your providing the requested written authorization. You have the right to revoke your authorization in writing as long as we have not acted in reliance on the authorization.

You have the following rights with respect to your Protected Health Information:

1. The right to request restrictions on our use and disclosure of your Protected Health Information for treatment, payment or health care operations. If we agree to any restriction, then we cannot violate that restriction except in the case of emergency treatment. However, we are not required to agree to any restrictions.

2. The right to request in writing and to receive confidential communications of your Protected Health Information by alternative means (such as by mail or email) or at alternative locations (such as your office or business workplace).

3. The right to request in writing access to our office to inspect and copy your Protected Health Information. Except in cases where the Protected Health Information is not maintained or accessible on-site, we will act on a request for access no later than thirty (30) days after we receive your request.

4. The right to request in writing that we amend your Protected Health Information. Your request must contain the reasons to support the requested amendment. We will act upon your request within sixty (60) days after we receive your request.

5. The right to receive an accounting of all our disclosures of your Protected Health Information in the six years prior to the date of your request, except for disclosures: (a) to carry out treatment,

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payment and health care operations; (b) to you; (c) for our directory or to persons involved in your care; (d) for national security or intelligence purposes; (e) to correctional institutions or law enforcement officials; (f) pursuant to any written authorization that you give to us; or (g) that occurred prior to April 14, 2003.

6. The right to request and obtain from us a paper copy of this Notice.

If you believe that we have violated your privacy rights, then you may file a written complaint with Dr. Maehara, who is our privacy officer. You may also file a complaint with the Office for Civil Rights of the DHHS. Your complaint must: (a) be in writing, either on paper or electronically; (b) name the Company and describe the acts or omissions you believed to be in violation of the Privacy Rules; (c) be filed within 180 days of when you knew or should have known that the act or omission complained of occurred, unless the time limit is waived by the DHHS for good cause shown. The complaint may be sent to: Office of Civil Rights, U.S. Department of Health and Human Services, Region IX, 50 United Nations Plaza, Room 322, San Francisco, CA 94102. We will not retaliate against you for filing a complaint. If you wish to obtain additional information about any of the matters discussed in this notice you may contact Dr. Maehara at 955-3937.

This Notice is effective as of March 15, 2003..

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