**PEDIATRIC OPTHALMOLOGY ASSOCIATES OF HAWAII**

DAVID YOUNG, MD
1319 PUNAHOU ST. SUITE 1030
HONOLULU, HAWAII 96826

## PATIENT INFORMATION

**Last Name:** _____ **First Name:** _____**DOB:** _____

**Gender:** ☐ Male ☐ Female **Home Phone:** (____) _____**Mobile Phone** (____) _____

**Mailing Address:** _____ **City:** _____ **State:** _____ **Zip Code:** _____

**Primary Care Provider or Pediatrician:** _____**Referring Physician:**_____

**EMERGENCY CONTACT INFO(other than parent/s): Name:** _____ **Phone #:** _____

**Relationship to patient:** _____

## PARENT/S OR LEGAL GUARDIAN/S INFORMATION

**MOM**

**Last Name:** _____

**First Name:** _____

**DOB:** _____ **SSN:** _____

**Mailing Address:** _____

**City/State/Zip Code:** _____

**Mobile Phone #:** _____

**Work Phone#:** _____

**Occupation:** _____

Is this the primary mailing address? Yes No

**DAD**

**Last Name:** _____

**First Name:** _____

**DOB:** _____ **SSN:**_____

**Mailing Address:** _____

**City/State/Zip code:** _____

**Mobile Phone #:** _____

**Work Phone#:** _____

**Occupation:** _____

Is this the primary mailing address? Yes No

## MEDICAL INSURANCE INFORMATION

| | INSURANCE | SUBSCRIBER'S ID | SUBSCRIBER'S NAME | DATE OF BIRTH |
|---|---|---|---|---|
| **Primary Insurance** | | | | |
| **Secondary Insurance** | | | | |
| **Other** | | | | |

_____
**INITIALS**

**INSURANCE BENEFIT ASSIGNMENT**
I request payment of authorized benefits be paid on my behalf to David A. Young, M.D. for any services furnished by David A. Young. I authorize Dr. David A. Young to release medical information about me to my insurance carriers.

_____
**INITIALS**

**NOTICE OF PRIVACY PRACTICES**
I have read or received a copy of Pediatric Associates of Hawaii's privacy practices. **(Copies available upon request.)**

_____
**INITIALS**

**ELIGIBILITY WAIVER**
I understand that eye exams for certain diagnoses may not be covered by some insurance plans, and that any charges not covered by insurance are my responsibility. I also understand that if the patient is not eligible under the terms of the insurance specified above or if the above is a misrepresentation of my coverage, I am liable for all charges for services rendered, and I agree to pay in full for all services received within thirty (30) days of receiving a bill from the above named doctor. I also understand that, if it is required, referral/authorization must be sent from my/my children's Primary Care Doctor to Dr. Young before I can be seen by him. If Dr. Young does not receive this referral/authorization from the Primary Care Doctor, I am liable for all charges.

## CONSENT TO TREAT MINOR

This will authorize Dr. David A. Young and other physicians under his supervision to provide medical care including examination, treatment, X-ray examination, photography, laboratory tests, local anesthetics, medical diagnosis, and hospital care to **(Name of Patient)** _____(**Date of Birth**) _____, a minor. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospitalization to avoid delay in providing such treatment as is deemed necessary by Dr. David Young. This authorization to treat will remain in effect until patient is 18 years of age unless revoked sooner in writing.

_____
Initials

This form authorizes said minor to present for minor care and treatment **unaccompanied by adult.**

_____
Initials

This form authorizes said minor to present for minor care and **treatment accompanied by an adult other than his/her legal guardian.**

_____ _____ _____

**Signature of Parent/Person having Legal Custody** **Print name of Parent/Person having Legal Custody** **Date**

## PATIENT'S MEDICAL HISTORY

**Patient's Name:** _____ **Date of Birth:** _____

**Reason for Today's Visit:**

_____

_____

Yes No Was the patient born prematurely? If yes, how many weeks at birth? (Full Term is 40 Weeks). _____

Birth Weight (please include) _____

Yes No Is there any problem/s during pregnancy, labor, delivery or after birth? If yes, please Describe.

_____

Yes No Does the patient ever have eye Surgery? If yes, what is the surgery for?

_____

Yes No Does this patient have any medical problem/s other than eye problem/? If yes, please list.

_____

Yes No Any previous surgery, hospitalizations, or recent injuries? If yes, please list.

_____

Yes No Does patient have any allergies or medication allergies? If yes, please list.

_____

Yes No Does patient take any eye medication? If yes, please list. _____

_____

Yes No Does patient take any other medication other than eye medication? If yes, please list.

_____

_____

Yes No Is there any medical problem/s that runs in the family? (i.e., Sticklers Syndrome, glaucoma, Diabetes, High Cholesterol, stroke, and hypertension). If yes, please describe.

_____

_____

Yes No Is there any eye problem/s run in the patient's family (including crossed eyes "lazy eye" Blindness, glaucoma, congenital cataract, retinoblastoma/eye tumor). If yes, please list.

_____

_____

_____ _____ _____

**SIGNATURE OF PARENT/LEGAL GUARDIAN** **PRINT PARENT NAME/LEGAL GUARDIAN** **DATE**