HUGO HIGA, M.D., LLC

1600 KAPIOLANI BLVD. #105 — HONOLULU HI 96814
98-1079 MOANALUA ROAD #660 — AIEA HI 96701
PHONE # 808-947-2020 FAX: 844-947-2088

PLEASE PRESENT ALL VISION AND MAJOR MEDICAL INFORMATION TO RECEPTIONIST

PATIENT NAME ________________________________ DATE ________________

ADDRESS ____________________________________ HOME PHONE ______________

CITY, STATE & ZIP ______________________________ CELL PHONE______________

BIRTHDATE ________/________ /________ SEX ☐ M ☐ F WORK PHONE______________

EMAIL ADDRESS ________________________________

MARITAL STATUS ☐ M ☐ S ☐ D SS# ________/________/________

REFERRING PHYSICIAN: ______________________________________

RESPONSIBLE PARTY FOR INSURANCE : (IF OTHER THAN SELF)

NAME ____ PHONE ( ) _________-________
LAST FIRST MIDDLE

ADDRESS ____ DOB: ______________________
STREET

____ SSN ________-_________-__________
CITY STATE ZIPCODE

EMERGENCY CONTACT:

NAME: ____ PHONE: ( ) __________-___________

RELATIONSHIP TO PATIENT: ____________________________________

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION TO INSURANCE COMPANY

I hereby authorize Dr. Hugo Higa or his representative to release to my insurance company or representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Dr. Hugo Higa. The assignment will remain in effect unless revoked by me in writing. **A photocopy of this assignment will be considered as VALID as an original**. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I will be assessed a $15.00 charge for each check returned due to insufficient funds. I further understand that a 1% finance charge (12% annually) maybe added to any balance over 90 days.In the event of default, I (we) promise to pay legal interest of the indebtedness, together with such collection costs and reasonable attorney fees as may be required to affect the collection of this note. **I hereby authorize said assignee to release all information necessary to secure payment.**

________________________________ ______________
Signature Date

INFORMATION REGARDING DILATING EYE DROP

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. **Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself**.Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.**I hereby authorize Dr.Hugo Higa and/or such assistants as may be designated by him/her to administer dilating eye drops.**

The eye drops are necessary to diagnose my condition.

________________________________ ________________
Patient (or authorized person to sign for patient) Date

PLEASE COMPLETE ALL PAGES OF THE FORM.

THANK YOU !