Medical History Record

Sakamoto Eye Clinic

1441 Kapiolani Blvd Suite 2005

Honolulu, HI. 96814-4408

(808) 944-9911

Appointment Date_____

Patient's Name (please print)_____

Date of Birth (MM/DD/YYYY) _____/_____/_____

Street Address_____

City_____State_____Zip_____

自宅 Home Phone_____

日中の連絡先 Daytime Phone_____

携帯電話 Cell Phone _____

予約の確認やお知らせをE-mail にてお送りしております。ぜひE-mail をお知らせ下さい。

We are sending appointment reminders and newsletters. Please let us know your e-mail address!

_____

Email ☐Please check if you do not want to receive e-mails from Sakamoto Eye Clinic.

当院からのE-mailを受け取りたくない場合は上記☐にチェックをお願いします。

Social Security Number _____

性別 Sex
☐男性 Male
☐女性 Female

婚姻 Marital status
☐ 独身 Single ☐ 死別 Widowed
☐ 既婚 Married ☐ 離婚 Divorced

社会人 Employed ☐Full-time ☐Part-time 学生 Student ☐Full-time ☐Part-time

☐無職 Not Employed ☐退職 Retired 職業 Occupation _____

勤務先･学校名 Employer/School Name _____

知人の紹介 How did you hear about us? _____

お名前Referral Name _____

かかりつけの内科医 Primary Care Physician

_____

保険筆頭者の名前（患者さん本人ではない場合）Subscriber Name (if different than patient)_____

保険筆頭者の（患者さん本人ではない場合）Subscriber's Social Security Number (if different than patient) _____

保険筆頭者の生年月日（患者さん本人ではない場合）Subscriber's Birth date (if different than patient) _____

下記の器官に問題があればチェックしてください。

Personal Medical Information: Do you have problem with any of these systems? If Yes, please check box.

☐**消化器系**Gastrointestinal ☐**神経系**Nervous System ☐**精神** Mental

☐**耳鼻咽喉**Ear/ Nose/ Throat ☐**生殖泌尿器系**Genitourinary ☐**内分泌系**Endocrine (Glands)

☐**心血管系**Cardiovascular ☐**筋骨格**Musculoskeletal ☐**血液リンパ**Blood/ Lymph

☐**呼吸器系**Respiratory ☐**皮膚**Skin

☐**アレルギー/免疫**Allergic/Immunologic ☐**頭痛**Headaches

☐**手術**Surgeries いつどんな手術をしましたか？ (what type & when)_____

薬のアレルギー Drug Allergies

_____

何かお薬を飲まれていますか？Do you take medications? _____

タバコ吸いますかDo you smoke? _____どれぐらい？How often? _____

アルコールは？Do you drink alcohol? _____どれぐらい？How often? _____

家族歴Family Medical History

☐ 糖尿 Diabetes ☐ 緑内障Glaucoma ☐ 高血圧High Blood Pressure

☐ 黄斑変性 Macular Degen. ☐ 網膜はく離 Retinal Detachment ☐**白内障**Cataract

次のような経験は？Do you have the following:

☐ ドライアイ Dry Eyes ☐ 目の手術Eye Surgeries☐ 眼鏡装用Wear Glasses

☐ 視力障害 Blurred Vision ☐**目のけが** Eye Injuries☐ コンタクトレンズ使用Wear Contacts

今目の症状が何かありますか？

Any eye problems at this time? Please explain? _____

Are you interested in 近視矯正レンズOrtho-K, CRT? (オルソーK、CRTに興味を持っていませんか？)

Yes ☐ No ☐

承諾書

Authorization to Release Information and Assignment of Benefits

保険請求で必要とされるならば私は医学上の情報を保険会社に公開することを認めます。
私は坂本アイクリニックが保険会社に直接連絡して保険受益を受け取ることを認めます。
私の保険会社が支払いを承認しなかった場合、自己負担となることを了承いたします。
I authorize the release of any medical or other information necessary to process the insurance claim.
I authorize payment of medical benefits to the Sakamoto Eye Clinic for services.
If my insurance company denies coverage for the service, I will take full responsibility of the payment.

署名 Signature　X_____

日付Date_____

緊急時の連絡先 Emergency Contact Name_____

関係Relation_____電話番号Phone_____

HIPPA NOTICE OF PRIVACY PRACTICES:
ACKNOWLEDGEMENT OF RECEIPT

THE ATTACHED NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

This HIPPA privacy law was made effective on **April 14, 2003.**
This form was adopted by the Sakamoto Eye Clinic on **September 26, 2013.**

I acknowledge that I, _____, have reviewed a copy of
(print **patient's** name)

the Sakamoto Eye Clinic's Notice of Privacy Practices with the effective date of _____ / _____ / 2014
(Today's date)

_____
(Signature or patient or patient representative)

Please circle one of the following to describe your relationship to the patient:

Self Spouse Parent Guardian Other (please specify):_____

If applicable, **please print patient representative's name:** _____

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