

CHANGMIN DUAN, O.D.

Patient Information Form

Name: _____ Mr.____ Mrs.____ Miss____ Dr.____ Other: _____

Address: _____ Phone # _____ Home: _____

City: _____ State: _____ Zip: _____ Phone # _____ Work: _____

Date of Birth: _____ Age: _____ Phone # _____ Mobile: _____

Occupation: _____ Email: _____

If minor, the name of Father: _____ Mother: _____ Legal Guardian: _____

Do you have Insurance Coverage?

Yes	No
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If yes, please list it (them): _____

Name(s) of the Policy Holder(s): _____

How did you learn of this office?: _____

If you were referred, by whom?: _____

Are there any members in your family that are patients of our office?

Yes	No
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If so, please name them: _____

When was your last physical examination? _____

List your Primary Care Physician:

Name: _____

Phone Number: _____

Address: _____

I hereby authorize payment of my medical and surgical insurance benefits to CHANGMIN DUAN. O.D. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Dr. Changmin Duan. I authorize Dr. Changmin Duan to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization maybe used in place of the original.

Signature

Date

Name: _____ Date: _____

Main Reason for Visit: _____

Circle all that apply	
Do you wear: N/A Glasses Soft Contact Lens Hard Contact Lens	
Have you ever had: N/A Spots/Floaters Flashes Eye Surgery Eye Injury Eye Turn Eye Strain	
Do you use computers for long hours? (>8 hr per day) Yes No	
Have you been told that you have: N/A Lazy eye or Amblyopia Cataracts Glaucoma Other Eye Disease	
Does anyone in your family have: N/A Glaucoma If yes, whom? _____ Other eye disease Specify: _____	

Circle all that apply	
Allergies: N/A Hay fever Dust Fungus Animals Humidity Foods Please specify allergies: _____	
Cardiovascular problems: N/A Hypertension Heart Disease Stroke Other (specify): _____	
Constitutional N/A Blackouts Car sickness Cramps Dizziness Disorientation Nausea Vomiting Other (specify): _____	
Endocrine problems: N/A Diabetes Thyroid problems Renal Disorder Other (specify): _____	
Gastrointestinal problems: N/A Heartburn Diarrhea Hepatitis Other (specify): _____	
Urinary Problems: N/A Pain or discomfort Prostate Disorder Bladder Problem Ovarian Disorder Other (specify): _____	
Ear / Nose / Throat Problems: N/A Hearing Loss Sore Throat Sinusitis Other (specify): _____	
Blood Diseases: N/A Anemia Hematologic disorder Lymphatic Other (specify): _____	
Immune problems: N/A Immunodeficiency Tuberculosis Other (specify): _____	

Skin Problems: N/A Acne Rashes Excessive dryness Dermatitis Other (specify): _____	
Musculoskeletal problems N/A Muscle aches Joint Pain Swollen Joints Arthritis Other (specify): _____	
Neurological problems N/A Brain Damage Dyslexia Epilepsy Seizures Spinal Cord Injury Other (specify): _____	
Psychiatric problems: N/A Depression Anxiety Insomnia Alzheimer Autism Other (specify): _____	
Respiratory Problems: N/A Asthma Shortness of Breath Bronchitis Emphysema Other (specify): _____	
Other medical conditions not noted above: N/A Cancer Pregnancy Specify: _____	
Have you ever had any surgery? Yes No Please specify: _____	
Does diabetes run in your family? Yes No If yes, whom? _____	
Does high blood pressure run in your family? Yes No If yes, whom? _____	
Do heart problems run in your family? Yes No If yes, whom? _____	
Do you smoke? Yes No	
If the patient is under 18 years old, are immunizations up to date? Yes No	

List any prescription or over-the-counter eye drops you use:

List any prescription or over-the-counter medications you use:

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Fax: (732) 246-2650

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name _____

Patient address _____

Patient phone number _____

I authorize the professional office of Changmin Duan, O.D.,P.A. to release health information identifying me, as necessary, for the purposes of obtaining medical treatment, facilitating the payment for such treatment and for normal business operations.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____ Patient signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(Initial) [] I received/was offered a copy of the "NOTICE OF PRIVACY PRACTICES"