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 |

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 |

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 Heptatitis

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 <u>18 years old</u>, 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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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"