CHANGMIN DUAN, O.D.

Patient Information Form

Name:		Mr	Mrs	s Miss_	Dr	Other:
Address:				Phone #		
City:	State:	_ Zip:		Phone #	Work:	
Date of Birth:	_	Age:		Phone #		
Occupation:			Email:			
If minor, the name of Father:		Mother:				Guardian:
Do you have Insurance Covera	ge? Y	'es	No	7		
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 If so, please name them:					Yes	No
When was your last physical exa	mination?					
List your Primary Care Physician						_
Name:						
Phone Number:						
Address:						
			_			
I hereby authorize pay DUAN. O.D. I understand I a insurance. If co-payments an plan, I agree to pay them to I information required to process authorization maybe used in plant.	m financiad/or deductor. Chango s any and	ally respo ctibles ar min Duar all claim	nsible e desi n. I a	e for any che gnated by a uthorize Dr	arges wh my insur . Chang	ance company or health min Duan to release any
Signature	Date	-				

Main Reason for Visit: Circle all that apply	Name:						
Skin Problems: N/A	Main Reason for Visit:						
Do you wear: Glasses Soft Contact Lens Hard Contact Lens Harde you ever had: Spots/Floaters Flashes Eye Surgery Eye Injury Eye Turn Eye Strain Do you wee computers for long hours? (>8 hr per day) Eye Turn Eye Strain Do you use computers for long hours? (>8 hr per day) Eyes No Have you been told that you have: Lazy eye or Amblyopia Cataracts Glaucoma Other Eye Disease Does anyone in your family have: Glaucoma If yes, whom? Other eye disease Specify: Circle all that apply Allergies: Hay fever Dust Fungus Animals Humidity Foods Please specify allergies: Cardiovascular problems: Hypertension Heart Disease Stroke Other (specify): Constitutional Blackouts Car sickness Cramps Dizziness Disorientation Nausea Vomiting Other (specify): Does diabetes run in your family? Yes No If yes, whom? Does high blood pressure run in your family? Yes No Off yes, whom? Does high blood pressure run in your family? Yes No If yes, whom? Does arryonder and any surgery? Yes No Other (specify): Other medical conditions not noted above: N/A Sthma Shortness of Breath Bronchitis Emphysema Other (specify): Other medical conditions not noted above: N/A Sthma Shortness of Breath Bronchitis Emphysema Other (specify): Other medical conditions not noted above: N/A Sthma Shortness of Breath Bronchitis Emphysema Other (specify): Other medical conditions not noted above: N/A Sthma Shortness of Breath Bronchitis Emphysema Other (specify): Other medical conditions not noted above: N/A Sthma Shortness of Breath Bronchitis Emphysema Other (specify): Other medical conditions not noted above: N/A Sthma Shortness of Breath Bronchitis Emphysema Other (specify): Other medical conditions not noted above: N/A Sthma Shortness of Breath Bronchitis Emphysema Other (specify): Other medical conditions not noted above: N/A Sthma Shortness of Breath Bronchitis Emphysema Other (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: N/A Washina Shortness of Breath Bronchitis							
Acre Rashes Excessive dryness Dermatitis	Circle all that apply]	Skin Problems: N/A				
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	Other (specify):	NT/A					
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			List any prescription or over-the-counter medications you use				
	Other (specify):	N T/ 4	1				
	Immune problems:	N/A					
	•						
Outer (specify):	Other (specify):						

Changmin Duan, O. D., P.A. 190 State Highway No.18, Suite 302 East Brunswick, NJ 08816

Tel: (732) 247-2847 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 fo 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 it we have already acted in reliance upon the authorization. If you want to revoke your authorization, send as 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 negal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as ne/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"