WELCOME

PATIENT INFORMATION (PLEASE PRINT)

LAST NAME	FIRST	MI	☐ MALE ☐ FEMALE	BIRTHDATE / /	AGE
ADDRESS	CITY	STATE	ZIP	GUARDIAN (IF APPLICABLE)	

HOME TEL ( )
WORK TEL ( )
CELL/ALT. TEL ( )

REFERRED BY:
RELATIVE / FRIEND _____
☐ INTERNET ☐ YELLOW PAGES ☐ INS. LIST ☐ WALK-IN ☐ OTHER

EMPLOYER	OCCUPATION	SOCIAL SECURITY #	DRIVERS LICENCE # EXP.

Email Address	Emergency Contact	Phone	Relationship

INSURANCE

1. Do you have Medical Insurance? Y N Name of plan: _____ ID# _____
2. Who is your Primary Care Physican? Name: _____
3. Do you have Vision (Optical) Insurance? Y N Name: VSP Eyemed Other _____

Please give your insurance cards to receptionist so copies can be made.

I hereby authorize the physician to release any information required to process insurance claims. I also authorize my insurance benefits to be paid directly to the physician and I understand I am financially responsible for non-covered services.

Signature: _____ Date: _____

PATIENT HISTORY

1. You are here for: ☐ Eye exam for glasses
   ☐ Contact lens exam ☐ Eye disease ☐ Laser surgery consult
   ☐ Other _____
2. Have you had your eyes examined in this office before? Y N
3. Last eye exam _____ from Dr. _____
4. Do you currently wear: ☐ Eyeglasses? How old? _____
   ☐ Contact Lenses? How old? _____
5. Have you worn: ☐ Eyeglasses When? _____
   ☐ Contact lenses in the past?
6. If you now wear contact lenses, fitted by _____
   Brand _____
   ☐ Gas Perm. ☐ Astigmatism ☐ Soft ☐ Color
   How often do you replace them? _____
7. What sports, hobbies do you enjoy? _____
   _____
8. Are you taking any medications? Y N
   Please list _____
   _____
9. Are you allergic to any medications? Y N
   Please list _____
   _____
10. Have you ever had an eye injury, disease, or eye surgery? Y N
    Please list _____
11. Do any immediate blood relatives have:
    ☐ Diabetes ☐ Glaucoma
    ☐ Cataracts ☐ macular degeneration

Do you have or have you ever had problems in the following areas?

	YES	NO	If yes, explain.
Loss of vision	☐	☐	
Blurred vision	☐	☐	
Double vision	☐	☐	
Burning / watery eyes	☐	☐	
light sensitivity	☐	☐	
flashes / floaters in vision	☐	☐	
cataracts	☐	☐	
Glaucoma	☐	☐	
Macular / retinal problems	☐	☐	
Other eye problems:	☐	☐	
Headaches	☐	☐	
Seizures	☐	☐	
Arthritis	☐	☐	
Thyroid problems	☐	☐	
Kidney problems	☐	☐	
Psychiatric	☐	☐	
Allergies / Hay fever	☐	☐	
Sinus problems	☐	☐	
Asthma	☐	☐	
High Cholesterol	☐	☐	
Diabetes	☐	☐	
High blood pressure	☐	☐	

NOTICE OF PRIVACY PRACTICES

As a patient, you have the right to adequate notice of the uses and the disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA), Dr. Chang and Dr. Yoon can use your protected health information for treatment, payment and health care operations. 1)Treatment - we may use or disclose your health information to a physician or other healthcare provider providing treatment to you. 2) Payment - We may use or disclose your health information to obtain payment for services we provide you. 3) Health Care Operations - We may use and disclose your health information in connections with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluation provider performance, conducting training programs, accreditations, certification, licensing or credentialing activities.

Your Authorization - Most uses and disclosures that do not fall under treatment, payment, or health operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations - In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

Marking - We will not use your health information for marketing communications without your written authorization.

Required by Law - We may also use or disclose your health information when we are required to do so by law.

Abuse or Neglect - We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglects, domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.

National Security - We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorizes under certain circumstances.

Appointment Reminders - We may use or disclose your health information to provide you with appointment reminders via phone, text, email or letter.

Your Rights as a Patient - You have the right to restrict the disclosure of your protected health information (in writing). The request for restrictions may be denied if the information is required for treatment, payment or healthcare operations. You have the right to receive confidential communications regarding your protected health information. You have the right to inspect and copy your protected health information. You have the right to amend your protected health information. You have the right to receive and account of disclosure of your protected health information. You have the right to a paper copy of this notice of privacy practices.

Legal Requirements - Dr. Chang and Dr. Yoon are required by law to maintain the privacy, of your protected health information, We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The polices in any new notices will not be in effect until they are posted to this site, or are available within our office.

Complaints - If you have complaints regards the way your protected health information was handled, you may submit a complain in writing to our office. You will not be retaliated against in any manner for a complaint.

Contact Information - For further information about Dr. Chang and Dr. Yoon's privacy policies, please contact Dr. Chang and Dr. Yoon at the following address or phone number: Matty Chang, O.D., Frank H. Yoon, O.D., 311 N. Tustin St., Suite B, Orange, CA 92867, (714) 997-7500.

PATIENT ACKNOWLEDGEMENT

I have read and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and how I may exercise these rights, and the practice's legal duties with respect to my information.

Patient Name:_____ **Signature:** _____ **Date:**_____