Date _____ Appt._____ WI _____

**Please Print.**

Last Name _____ First Name_____ Mr./Mrs./ Ms. (circle one)

Address _____ Apt# ____ Date of Birth ____/____/____ Age _____

City _____- State _____ Zip Code _____

Cell Phone (____)_____-_____ Home Phone (____)_____-_____

Email Address _____

Occupation _____Have you ever been examined in our office? Yes / No

Are you here for: spectacle exam / contacts exam / medical treatment visit (circle one)
Have you worn contacts in the past? YES / NO If yes, what type_____

Name of ***VISION INSURANCE*** _____
Name of ***MEDICAL INSURANCE(i.e.BC/BS,AETNA)*** _____
Do you have insurance that you are using as payment for services rendered today? _____
If you answered yes to the question above, an additional form needs to be filled out. The front desk will supply you with this form .
Are you interested in Lasik surgery?_____

***CHECK ALL THAT APPLIES:***

**Patient Current Eye Health**

**Date of Last Eye Exam**_____

- ❑ Blurry Vision
- ❑ Double Vision
- ❑ Dry
- ❑ Eyestrain
- ❑ Floaters / Flashes
- ❑ Halos
- ❑ Itching
- ❑ Sandy / Gritty Feeling
- ❑ Tearing
- ❑ Other_____

**Patient Eye History**

- ❑ Color deficient
- ❑ Eye injury
- ❑ Eye surgeries
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Retina Detachment
- ❑ Retinal Tear
- ❑ Vision loss
- ❑ Vision therapy
- ❑ Other_____

**Patient Current / Past Medical History**

**Date of Last Medical Exam:**_____

- ❑ Allergies _____
- ❑ Hematological /Lymphatic (Blood Disorders)
- ❑ Allergies to Medications _____
- ❑ Immunologic (Lupus, HIV)
- ❑ Cancer _____
- ❑ Integumentary (Skin, Melanoma)
- ❑ Cardiovascular (Heart Attack, Hypertension)
- ❑ Musculoskeletal (Muscles, Joints)
- ❑ Constitutional (Rapid weight changes)
- ❑ Neurological (Migraines, Seizures, MS)
- ❑ Ear, Nose, Throat, Mouth
- ❑ Psychiatric (Anxiety, Depression, ADHD)
- ❑ Endocrine / Metabolic (Thyroid, Diabetes)
- ❑ Respiratory
- ❑ Gastrointestinal
- ❑ Genitourinary (Genitals, Kidneys, Bladder)

**WOMEN ONLY:** ❑ Pregnant? _____
❑ Oral Contraceptives? _____

***Family* Eye & Health History**

- ❑ Amblyopia / Strabismus
- ❑ Blindness
- ❑ Cataracts
- ❑ Color deficient
- ❑ Diabetes
- ❑ Glaucoma
- ❑ High Blood Pressure
- ❑ Macular Degeneration
- ❑ Migraines
- ❑ Retinal tear / Detachment
- ❑ Other _____

**Social History**

*(This information is a protected part of your medical record. It is confidential. If you prefer you may discuss this portion of your medical history directly with the doctor).*

Do you smoke / use tobacco products? yes ❑ no ❑
Do you drink alcohol? yes ❑ no ❑

**MEDICATIONS:**
*List ALL prescribed and over the counter medications. including eye drops, vitamins, and narcotics.*

**Authorization**

I certify that the above questions are answered to the best of my knowledge.

_____ _____
Signature of Patient (or parent if minor) Date

Physician Review (initials)_____

_____
Date

**PLEASE PRINT** DATE: _____

**PRIMARY INSURED MEMBER INFORMATION**

INSURANCE COMPANY_____

PHONE NUMBER ON CARD_____

PRIMARY MEMBER NAME _____

ADDRESS_____

_____ZIP CODE_____

PLEASE CIRCLE GENDER: MALE FEMALE

TELEPHONE NUMBER (_____)-_____--_____

MEMBER DATE OF BIRTH_____-_____-_____

MEMBER SOCIAL SECURITY NUMBER _____-_____-_____

ID NUMBER (IF DIFFERENT THAN SS#) _____

EXAM TYPE (PLEASE CIRCLE) SPECTACLE – CONTACTS - MEDICAL TREATMENT VISIT

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM. DR DEYONG WILL TAKE ASSIGNMENT AND SUBMIT THIS CLAIM TO YOUR INSURANCE CARRIER FOR PAYMENT. HOWEVER, IN THE EVENT THAT YOUR INSURANCE CARRIER DETERMINES THAT YOU ARE NOT ELIGIBLE FOR THESE BENEFITS, YOU WOULD BE RESPONSIBLE FOR PAYMENT.

**SIGNATURE**_____

++++++++**PROCEED ONLY IF PATIENT IS NOT PRIMARY INSURED MEMBER**++++++++

PATIENT NAME: _____

ADDRESS (If different from above) _____

_____ZIP CODE_____

TELEPHONE NUMBER (_____)-_____-_____DATE OF BIRTH____/____/_____

RELATIONSHIP TO INSURED MEMBER_____

EXAM TYPE (PLEASE CIRCLE) –SPECTACLE –CONTACTS -MEDICAL TREATMENT VISIT

++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++

**FOR OFFICE USE ONLY** **Date** _____

VOUCHER

PLEASE MAKE TWO COPIES OF INSURANCE CARD

PATIENT NAME_____

INS COMPANY_____

CO PMT_____

BILLING FOR MATERIALS YES NO GLASSES OR CONTACTS

TYPE OF EXAM SPEC CLE MTV MTV FU GLAU CAT

NEW PT PREV PT

# DEYONG'S EYEWORLD
# ACKNOWLEDGEMENT OF PRIVACY PROCEDURES

| Please Print Your Name | Date of Birth | Social Security Number |
|---|---|---|
| | | |

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND ANSWER ALL THE QUESTIONS.

This Notice of Privacy Procedures describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment and/or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, and any other use required by law.

TREATMENT:
We will use your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you, to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you and/or review your health information with a case manager who is coordinating your care.

PAYMENT:
Your protected health information will be use, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS (TPO):
We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting/arranging for other business activities. For example, we may disclose your protected health information to:

- Medical school students that see patients at our office.
- We may use a sign-in sheet at the registration desk where you are asked to sign your name and indicate your physician.
- We may call you by name in the waiting room when your physician is ready to see you.
- We may use or disclose your protected health information, as necessary to contact you to remind you of your appointment.
- With your specific approval, leave information at your home on an answering machine or to a duly authorized person acting on your behalf.

We may use or disclose your protected health information in the following situations without your authorization. These situations include:

- As Required by Law;
- Public Health issues as required by law – communicable diseases, health oversight, abuse or neglect;
- Food and Drug Administration requirements;
- Legal proceedings;
- Law enforcement, Criminal activity, Inmates;
- Coroners, Funeral Directors, and Organ Donation;
- Research;
- Military Activity, National Security
- Workers' Compensation.

Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500..

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOU'RE RIGHTS:
Following is a statement of your rights with respect to your protected health information.

- You have the right to inspect and receive a copy your protected health information. Under federal law, however, you may not inspect or copy Psychotherapy notes.
- Information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding;
- Protected health information that is subject to law that prohibits access to protected health information.
- You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to your family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Procedures. Your request must state the specific restriction(s) requested and to whom you want the restriction(s) to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
- You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a coy of this notice, upon request.
- You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You have the right to object or withdraw as provided in this notice.

You may complain to use or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying any supervisor, a member of our administration, or our designated Privacy Officer.

This notice was published and becomes effective April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy procedures with respect to your protected health information. If you have any objections to this form, please notify our Administration at (732) 634-8600.

Please answer the questions below and affix your signature acknowledging that you received this Notice of our Privacy Policy and Procedures and have provide specific direction and authorization in protecting your health information.

- Who may we provide with your personal health information? (Check all that apply.)
  ☐ Spouse ☐ Children ☐ Parent ☐ Others, specify _____
- May we leave personal health information on your answering machine at home?
  ☐ YES ☐ NO

| | |
|---|---|
| _____ | _____ |
| Patient's Signature | Today's Date |