

**PATIENT INFORMATION**

Name \_\_\_\_\_ M / F Age \_\_\_\_\_ Birthday \_\_\_\_\_  
 Last First Mid.

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Phones Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Primary Insurer Name \_\_\_\_\_ Birthday \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Last eye exam date \_\_\_\_\_ Dr.'s name / Location \_\_\_\_\_ Referred by \_\_\_\_\_

Age of current glasses/ contact lens \_\_\_\_\_ Hours of contact lens worn per day \_\_\_\_\_  Hard  Soft  Toric Brand \_\_\_\_\_

Are you pregnant or nursing?  Yes  No Are you interested in LASIK, Vision Correction thru Contact Lens  Yes  No

Check all symptoms you are experiencing:

- Itchy Eyes                       Eyestrain                               Light Sensitivity                       Flashes                               Headaches
- Pain/Soreness                       Dryness/Sandy                               Double Vision                               Redness                               Floaters
- Watery                               Lid Twitch                               Discharge                               Others: \_\_\_\_\_

Do you or any blood relatives have any of the following:

	Self	Relatives		Self	Relatives		Self	Relatives
Retinal disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Skin condition	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric condition	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Muscle/joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Urogenital	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

Name of primary physician: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

List types of medication currently taking: \_\_\_\_\_

List any medications including eye drops you are allergic to: \_\_\_\_\_

List any history of eye diseases, injuries, or surgeries: \_\_\_\_\_

List types of sports and hobbies: \_\_\_\_\_ Hours spent on computer, video games, TV, reading per day? \_\_\_\_\_

Do you (check all that apply)     smoke                       drink                       use drugs

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE**

I've acknowledged and agreed to Dr. Bogard Chang Notice of Privacy and a copy of the Notice of Privacy had been made available for me to keep for my records on the date identified below.

I request that payment of authorized insurance benefits be made on my behalf to Dr. Bogard Chang, O.D. for services furnished. I authorized the release of any medical or other information necessary to process this claim.

I agree to undergo an arbitration to resolve any disputes prior to filing a court lawsuit.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent, Legal guardian, Care taker \_\_\_\_\_ Date \_\_\_\_\_

Reviewer Signature \_\_\_\_\_ Date \_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ AGE: \_\_\_\_\_

DATE: \_\_\_\_\_

CC: \_\_\_\_\_ CL \_\_\_\_\_

Km \_\_\_\_\_

No change in medical health since last visit

Oc. Hx: ( ) glc ( ) cat ( ) inj/surj ( ) \_\_\_\_\_

Med. Hx: ( ) DM ( ) HTN Allergies: Meds: \_\_\_\_\_

VA< OR

Hab Srx / CL / sc \_\_\_\_\_ Near P R R L ( ) APD NPC: TTN: <5 <10 <15 cm  
EOMS: full \_\_\_\_\_ CONF: OD \_\_\_\_\_ OS \_\_\_\_\_  
Cover test D \_\_\_\_\_ N \_\_\_\_\_ Color \_\_\_\_\_ ou  
Other: \_\_\_\_\_

A)

Add \_\_\_\_\_ Auto \_\_\_\_\_  
Ret. \_\_\_\_\_

SUBJ: OD: \_\_\_\_\_ 20/ \_\_\_\_\_

FINAL Rx  
(TF)

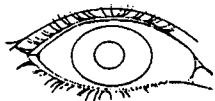
P)

OS: \_\_\_\_\_ 20/ \_\_\_\_\_

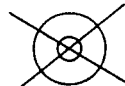
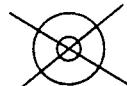
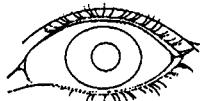
ADD / amp \_\_\_\_\_ RS \_\_\_\_\_ OU \_\_\_\_\_

Wet OD  
OS

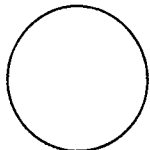
GAT: OD \_\_\_\_\_ OS \_\_\_\_\_ am pm 1gt  Tetaim  1% Mydral  2.5% Neofrin OD OS OU



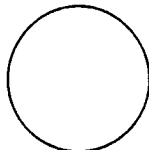
Lids  
Lashes  
Conj  
Cornea  
Iris  
A/C  
Angles  
Lens



DO//BIO/90



Vitreous  
ONH  
Margin  
C/D  
A/V  
Macular  
Periphery



A).

P)

RTC 1 2 3 6 wk mon yr Dr. Sign Date

Comprehensive	92004	Visual Field Compreh 30-2	92083	Silicon Plugs	68761	E1, E2, E3, E4
	92014 est	Intermediate	92082	Extend Slit Lamp (MCal)	Z2704	
Intermediate	92002	screening	92081	Collagen Plugs (MCal)	Z2712	
	92012 est	Fundus Photo	92250 R, L	Gonioscopy	92020	
Refraction	92015	Laser Scan	92135 R, L	Pachymetry	78514	
		Blood Flow	92499			
		Punctual dilate irrigate	68801			
E / M Moderate	99204	Epilation (slit lamp)	67820			
	99214 est	<input type="checkbox"/> Patient has history of inability to adapt bifocals symptom of nausea, double vision, HA, dizziness 2 prs SV in lieu of				
Detail	99203	were prescribed				
	99213 est	<input type="checkbox"/> Patient lost glasses and can't find them even after several attempts				
Expand	99202	<input type="checkbox"/> Patient's frame were broken beyond repair no signs of abuse				
	99212 est					