PATIENT INFORMATION

Name _____ M / F Age _____ Birthday _____
Last First Mid.

Address _____ City _____ Zip _____

Soc. Sec. # ___-___-____ Employer _____ Occupation _____

Phones Home ( ) _____ Work ( ) _____ Cell ( ) _____

Email: _____

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	☐	☐	Arthritis	☐	☐	Skin condition	☐	☐
Cataracts	☐	☐	High blood pressure	☐	☐	Psychiatric condition	☐	☐
Glaucoma	☐	☐	High cholesterol	☐	☐	Thyroid disease	☐	☐
Diabetes	☐	☐	Lung disease	☐	☐	Muscle/joint pain	☐	☐
Asthma	☐	☐	Heart disease	☐	☐	Allergy	☐	☐
Urogenital	☐	☐	Cancer	☐	☐	Other: _____		

Name of primary physician: _____ Date of last physical: _____

List types of medication currently taking: _____

List any mediations 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: _____

CC:

No change in medical health since last visit [1]
Oc. Hx: ( ) glc ( ) cat ( ) inj/surj ( ) _____

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

Hab Srx / CL / sc Near

_____ 20/___ _____

_____ 20/___ _____

Add_____

SUBJ: OD:_____ 20/ ____

OS:_____ 20/ ____

ADD / amp_____ RS_____ OU ____

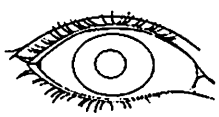
Wet OD
OS

P R R L ( ) APD NPC: TTN: <5 <10 <15 cm
EOMS: full_____ CONF: OD_____ OS_____
Cover test D_____N_____Color_____ou
Other:

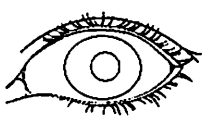
Auto_____
Ret.
_____

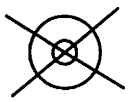
FINAL Rx
(TF)

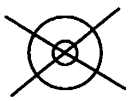
GAT: OD_____OS_____ am pm 1gt Tetain 1% Mydral 2.5% Neofrin OD OS OU



Lids
Lashes
Conj
Cornea
Iris
A/C
Angles
Lens

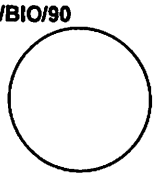




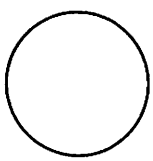


Pach

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

DATE: _____

CL _____

Km _____

_____

VA OR

MOB Lag Sag 0.5 ou

A)

P)

Comprehensive	92004		Visual Field Compreh 30-2	92083	
	92014	est	Intermediate	92082	
Intermediate	92002		screening	92081	
	92012	est	Fundus Photo	92250	R, L
			Epilation (slit lamp)	67820	
Refraction	92015		FB remove conj embed	65210	
			FB remove cornea SL	65222	
E / M Moderate	99204		Gonioscopy	92020	
	99214	est	Pachymetry	76514	
Detail	99203		Anterior Photo	92285	
	99213	est	Punctal dilation irrigate	68801	
High	99205		Silicon Plugs E1, E2 , E3 , E4	68761	
	99215	est			