

**Welcome to our office....**  
**NEW PATIENT LETTER**

**Dear Patient,**

We appreciate your selection of our office for your complete eye care. First visits usually take approximately 1 hour. Dilation of your eyes will probably be required for the examination. Since the effect of this procedure can take three to four hours to wear off, it is best that you not plan on driving immediately after the appointment and that you arrange for other means of transportation to return home.

We have enclosed a Patient Registration Form and Medical History Questionnaire. Please complete these forms at home as completely as you are able to and bring them with you to your appointment. Also, please bring a list of any medications and eye drops that you are currently using, along with your eyeglasses or contact lenses. Be sure you have all of your insurance cards with you when you come to the office.

There are over 1000 insurance plans in America. It is the responsibility of the patient to know and understand policies and benefits of their insurance plans. This includes co-payments, deductibles, contracted providers (physicians, hospitals, laboratories, radiology, etc.) and current claims address.

We have also enclosed a medical records release form. Please fill in the requested information and mail or fax to your previous ophthalmologist's or optometrist's office from whom you would like us to receive your medical records. This will help in facilitating the quality and continuity of your care.

As a courtesy, we will bill your insurance for services provided at the time of your visit. If there are any changes to you insurance plan(s), please inform us immediately.

We will bill Medicare for you if you are a Medicare patient. Applicable co-payments and deductibles will be collected from you for all insurance plans with which we participate. Payment is requested at the time of the office visit for any co-payments or non-insurance service. Unless you have purchased vision coverage with your insurance plan, a refraction or an exam to check your prescription for glasses or contact lens is not included in your office visit. There will be a \$45.00 charge for this service. Dr. Doan does not make glasses in the office or order contact lenses, however, she will give you a prescription to have this filled at another facility. If you do not have one that you prefer, Dr Doan can recommend one. A \$25.00 charge will be applied for any returned checks.

Your insurance is a contract between you, your employer and the insurance company. If you are deemed ineligible for your insurance benefits at the time of service, you are responsible for payment immediately upon receipt of your billing statement.

We would like to thank you for choosing our office as your partner in your eye care health and needs.

We look forward to seeing you. If you have any questions or need to reschedule your appointment (give at least 24 hours notice), please call us at 714.965.0300 or 949.645.6300.

Sincerely,

*Kim T. Doan, M.D. and Staff*

# Advanced Eyecare of Orange County

## Kim Doan, M.D.

355 Placentia Ave #305, Newport Beach, CA 92663  
19582 Beach Blvd #102, Huntington Beach, CA 92648

Phone: 949.645.6300  
Phone: 714.965.0300

### PATIENT INFORMATION

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

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Address: \_\_\_\_\_ City, State: \_\_\_\_\_

Zip: \_\_\_\_\_ Phone# ( \_\_\_\_\_ ) - \_\_\_\_\_ Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_

Sex  M  F  Marital Status  S  M  D  W  Ethnicity  Hispanic/Latino  Not Hispanic Latino

Race  American  Indian  Asian  Black/African American  Black Hispanic or Latino  Pacific Islander  White  White

Hispanic/Latino Language Preference  English  Spanish  Vietnamese  Chinese Other: \_\_\_\_\_

Driver License No.: \_\_\_\_\_ Social Security No.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_ Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Business Address/Name: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Referred by: Friend/Relative: \_\_\_\_\_ Doctor: \_\_\_\_\_

### PERSONAL INSURANCE INFORMATION (Must complete for Billing)

Primary Insurance Co: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Address: \_\_\_\_\_ Certificate #: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Group#/Name: \_\_\_\_\_

Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_ Relationship: \_\_\_\_\_

### Name of Nearest Relative or Friend---Not Living With You ( For Medical Emergency)

Name: \_\_\_\_\_ Phone #( \_\_\_\_\_ ) \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

### AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Kim T. Doan, M.D. to furnish information to insurance carriers on my behalf concerning my illness, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance benefits. A photocopy of this assignment is as valid as the original.

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

# Patient History Form

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Birth Date \_\_\_\_\_

Referred by \_\_\_\_\_

**REVIEW OF SYSTEMS**  
Do you currently have any of the following problems?

1. Please list <b>ALL medication</b> you are taking, including eye drops.		If YES, please explain.
2. Do you have any allergies to any medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. <b>Constitutional</b> (fever, weight loss, other)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. <b>Eyes</b> (glaucoma, cataract, lazy eye, retina problems, other - please specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Previous eye lasers/surgery/injury?</b>
5. <b>Ear / nose / mouth / throat</b> (hearing loss, sinus problems, sore throat)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. <b>Cardiovascular</b> (heart problems, chest pain, irregular heart beat, <b>HYPERTENSION</b> )	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. <b>Respiratory</b> (asthma, shortness of breath, wheezing, coughing)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. <b>Gastrointestinal</b> (heartburn, abd. pain, diarrhea, vomiting)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. <b>Genitourinary</b> (urinary problems, blood in urine)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. <b>Integumentary</b> (skin rashes, excessive dryness)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. <b>Musculoskeletal</b> (muscle aches, joint pain, swollen joints)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. <b>Neurological</b> (numbness, weakness, headaches, paralysis)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13. <b>Hematologic/Lymphatic</b> (blood disorders, leukemia)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. <b>Allergic/Immunologic</b> (hay fever, allergies)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15. <b>Endocrine</b> (thyroid problems, <b>DIABETES, ELEVATED CHOLESTEROL/LIPIDS</b> )	<input type="checkbox"/> Yes <input type="checkbox"/> No	
16. <b>Psychiatric</b> (depression, anxiety)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Family history:** Do any eye diseases run in your family?

- Glaucoma
- Macular degeneration
- Strabismus/"lazy eye"
- Retinal Detachment
- Blindness/loss of vision

**Social History:**

Last eye exam \_\_\_\_\_  
Dilated? Yes / No

Do you smoke? Yes / No  
If yes, how much? \_\_\_\_\_

Drink alcohol? Yes / No  
If yes, how much? \_\_\_\_\_

**Any areas of concern:**

- Fine lines/wrinkles
- Major lines around mouth & nose
- Decreased vision (distance or near)
- Glare/halos/Cataracts
- Droopy Eyelids
- OTHER: \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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## PATIENT RESPONSIBILITIES

1. You have the responsibility to provide *accurate and complete* information concerning your present complaints, past medical history and other matters relating to your health.
2. You have the responsibility for making it known whether you *clearly comprehend* the course of your medical treatment and what is expected of you.
3. You have the responsibility for *following the treatment plan* established by your physician, including the instructions of nurses and other health professionals as they carry out the physician's orders, including return visits.
4. You have the responsibility for assuring the *financial obligations* of your care are fulfilled.
5. You have the responsibility for inquiring about information regarding *Advance Directives (Durable Power of Attorney for Health Care, Natural Death Act Declaration or Living Will)* from your primary care physician or the Member Services Department from you Health Plan.
6. You have the responsibility to *treat all providers, office personnel and other patients* respectively and courteously.
7. You have the responsibility to *communicate openly* with your physician so that you can develop patient-physician relationship based on trust and cooperation
8. You have the responsibility to *seek and obtain services* as consistently as possible.
9. You have the responsibility to *take charge* of your health, make positive choices and seek appropriate care when needed.
10. You have the responsibility to consider the *possible consequences* if you refuse to follow the physician's orders or comply with the recommended treatment.
11. You have the responsibility to keep *appointments* or give adequate notice of delay or cancellation.
12. You have the responsibility to *read* all Plan materials carefully as soon as you enroll and to ask questions when necessary.
13. You have the responsibility to *help* your physician to *maintain* accurate and current medical records by being open and honest when you provide necessary information.
14. You have the responsibility to *constructively* express your opinions, concerns, and complaints to the appropriate people with you Health Plan.
15. *You have the responsibility to call you physicians' office after a reasonable period of time when you have any type of laboratory test, x-ray or pathology results pending.*

I have been informed of my responsibilities and I understand them fully.

\_\_\_\_\_  
Patients Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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## ELIGIBILITY WAIVER

<b>Patient Name:</b>	<b>Health Plan:</b>
<b>ID Number:</b>	<b>Effective Date:</b>
<b>Physician Name:</b> <b>Kim T. Doan, M.D.</b>	

**The Patient or Patient's Legal Representative hereby certifies that he/she is eligible for health plan benefits coverage, and has chosen the above stated physician as the provider of his/her health care.**

**Furthermore, the Patient/Patient's Legal Representative understands that if he/she is found ineligible for coverage of plan benefits, he/she is financially responsible for all costs incurred during the delivery of health services, and agrees to pay these charges to the physician accordingly.**

\_\_\_\_\_  
*Signature of Patient/Guardian*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Date*

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## Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate:

Relationship:

- Parent or guardian of minor patient
- Guardian or conservator of incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_

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Unfortunately, Medicare and other medical plans do not cover examination for glasses, which includes refractive eye exams. This procedure can be done in addition to your medical exam if requested. The fee for a refraction/refractive exam is **\$45.00** and is due at the time of service.

*(Note: Dr. Doan does not participate in Vision plans/insurance. If you have vision insurance, we can give you an invoice and you can try to bill or get reimbursement from your vision insurance. If you do not need a new prescription you will not be charged even though Dr. Doan performed the exam. If you require a prescription for new glasses or contact lenses then there will be a \$45.00 charge)*

\_\_\_\_\_ **YES**, I wish to have this exam performed today.

\_\_\_\_\_ **NO**, I do not wish to have this exam performed today.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Date*

\_\_\_\_\_  
**Printed Name**