WELCOME TO OUR OFFICE

Patient Information

(Please fill out all available spaces)

Dr. DAVID W. BANG
OPTOMETRIST

Date:_____

Last:_____ First:_____ MI:____ Male / Female

Street:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell:_____ Email Address:_____

Patient's SSN:___-___-_____ Date of Birth:____/____/____ Age:_____ Height:_____ Weight:_____

Employer or School:_____ Occupation or Grade:_____ Marital Status: Married ____
Single ____
Divorced ____
Widowed ____
Separated ____

Spouse or Parent's Name:_____ Spouse or Parent's Work:_____

What is the purpose of your visit today?_____

How were you referred to our office?
(Please mark any that apply)

- ○ Phone Book
- ○ Insurance Listing
- ○ Online Search
- ○ Drive by
- ○ School
- ○ Doctor (Name)_____
- ○ Family/Friend (Name)_____

Primary care physician:_____

Clinic Name:_____

Date of last health exam:_____

Last Eye exam:_____

Vision Insurance: _____

Subscriber Name:_____
Subscriber SSN:___-___-_____
Subscriber Birth Date:____/____/____

Primary Medical Insurance: _____

Subscriber Name:_____
Subscriber SSN:___-___-_____
Subscriber Birth Date:____/____/____

Secondary Medical Insurance: _____

Subscriber Name:_____
Subscriber SSN:___-___-_____
Subscriber Birth Date:____/____/____

Current Medications (RX or over the counter)
(List the name of the *medications* including *eye drops, birth control, vitamins*)

_____

_____

_____

If you have been diagnosed or treating any of the following please indicate them below. (please mark any that apply to you and blood related family members)

	Self	Family		Self	Family
Allergies	___	___	Eczema/Rashes	___	___
Arthritis	___	___	Fatigue	___	___
Blood/Lymph	___	___	Fevers	___	___
Bronchitis	___	___	Genitourinary	___	___
Cancer	___	___	High Blood Pressure	___	___
Cholesterol	___	___	Integumentary (skin)	___	___
Diabetes	___	___	Kidney	___	___
Digestive	___	___	Muscle/Bone	___	___
Ears/Nose/Throat	___	___	Neurological	___	___
Endocrine	___	___	Psychological	___	___
Respiratory	___	___	Sinus	___	___
Throat Infections	___	___	Thyroid	___	___

Other_____

Allergies to Medications? ( )Yes ( )No

If so, what medications?_____

_____

Have you had any surgeries? ( )Yes ( )No

If yes, please list _____

Do you drink alcohol? ( )Yes ( )No

If yes, how much/often? _____

Do you smoke? ( )Yes ( )No

If yes, how much/often? _____

Do you use any other substances'? ( )Yes ( )No

If yes, please list _____

Have you ever had a blood transfusion performed? ( )Yes ( )No

Have you ever been treated for a STD (i.e., herpes, HIV, AIDS, etc.)? ( )Yes ( )No

If yes, please list _____

Please make sure you have your most current medical and vision insurance information on file. If you are using medical and/or vision insurance coverage for today's visit, please be aware that this is a contract between you and your insurance company. We are happy to file a claim to your insurance company on your behalf; however this is not a guarantee of payment. You/Guardian are responsible for any balances left unpaid. I authorize release of any information concerning my (or my child's) healthcare, advice or treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, directly paid to the doctor.

☐ **I have read and understand the above paragraph**

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been told of HIPPA and have been offered a copy of the privacy policy by the Dr. David Bang staff.

☐ **I understand** ☐ **I would like a copy** ☐ **I would like more information**

_____ _____

Signature Date

DAVID W. BANG, O.D.
Doctor of Optometry

American Optometric Association

Retinal Fundus Photography

Dear Patient,
A highly sophisticated computerized instrument now allows us to provide you with a more thorough medical analysis of your eye health. The digital retinal imaging system takes images of the retina (the back of the eye). The procedure assists the doctor in the early detection of many disorders, including cataracts, glaucoma, diabetic retinopathy, macular degeneration, retinal detachments, and other vision threatening conditions. The images will be stored in our computer and compared with images from future exams. This allows the doctor to observe even the smallest amount of change from the previous procedure.

This test **should be** part of your exam if:

1) You are a new patient to this office. (To establish a baseline)
2) You have never had retinal photos
3) You are 65 years or older
4) You have high cholesterol, elevated blood pressure, or any circulatory disorder
5) You have diabetes or elevated blood sugar
6) You have flashes, floaters, or veils
7) You have elevated eye pressure or glaucoma
8) You have headaches or visual disturbances suggestive of a neurological problem
9) You have had any retinal disorder such as detachment, tear, floaters, flashing lights, bleeding or macular degeneration.
10) Your vision is not correctible to 20/20 in one or both eyes.

"Screening retinal photography" is a necessary part of your eye exam if you fall into any of the above categories. We will bill your **medical** insurance company or Medicare for this diagnostic procedure. **You will be responsible for the co-pay and any amount that went toward your deduct. We will bill you for the co-pay/deduct, if there is any.**

_____ I have read and do understand the billing procedures for the Retinal Fundus Photographs

Signature (Parent if patient is a minor) Date