PATIENT INFORMATION

NAME (LAST, FIRST, MIDDLE)			SS#	DOB	GENDER
STREET ADDRESS					
CITY	STATE	ZIP	EMAIL		
HOME PHONE			CELL PHONE		
PRIMARY EMPLOYER			WORK PHONE		
WHO IS YOUR PRIMARY CARE PHYSICIAN?					

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

NAME (LAST, FIRST, MIDDLE)	SS#	DOB	GENDER
STREET ADDRESS	CITY, STATE, ZIP		
HOME PHONE #	RELATIONSHIP TO PATIENT		

INSURANCE INFORMATION

PRIMARY INSURANCE	POLICY #		
NAME OF INSURED	RELATIONSHIP TO PATIENT	DOB	GENDER
STREET ADDRESS			
CITY, STATE, ZIP		COPAY AMOUNT	
SECONDARY INSURANCE	POLICY #		
NAME OF INSURED	RELATIONSHIP TO PATIENT	COPAY AMOUNT	

WHO SHALL WE CALL IN CASE OF EMERGENCY?
PLEASE PROVIDE THEIR NAME, RELATIONSHIP TO YOU, AND PHONE NUMBER

NAME: RELATIONSHIP: PHONE:

IS ANYONE AUTHORIZED TO MAKE INQUIRIES TO OUR OFFICE ON YOUR BEHALF?
IF SO, PLEASE PROVIDE THEIR NAME AND THEIR RELATIONSHIP TO YOU

NAME: RELATIONSHIP:

HOW DID YOU HEAR ABOUT OUR OFFICE?
[ ] FAMILY/FRIEND [ ] PATIENT [ ] NEWSPAPER [ ] OTHER _____
IF REFERRED BY FAMILY, FRIEND, PATIENT, OR ANOTHER DOCTOR, PLEASE GIVE THEIR NAME AND ADDRESS

NAME: ADDRESS:

_____ _____

SIGNATURE OF PATIENT/REPRESENTATIVE DATE

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ DATE: _____

BIRTH DATE: _____ DATE OF LAST EYE EXAM: _____

MEDICAL HISTORY

MEDICAL PROBLEMS: _____

CURRENT MEDICATIONS: _____

_____

_____

EYE PROBLEMS: _____

CURRENT EYE DROPS: _____

_____

ALLERGIES TO MEDICATIONS: _____

DO YOU HAVE ANY PROBLEMS IN THE FOLLOWING AREAS? IF "YES," PLEASE PROVIDE INFORMATION.

GENERAL/CONSTITUTIONAL	**YES**	**NO**	
FEVER			
WEIGHT LOSS			
OTHER			

EARS, NOSE, THROAT (SINUS, EAR INFECTION, CHRONIC COUGH, DRY MOUTH, ETC)			

CARDIOVASCULAR (HIGH BLOOD PRESSURE)			
RESPIRATORY (ASTHMA, EMPHYSEMA, ETC.)			
GASTROINTESTINAL (STOMACH ULCERS, INTESTINAL DISEASE, ETC.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (ARTHRITIS, ETC.)			
SKIN (ECZEMA, SKIN CANCER, ETC.)			
NEUROLOGICAL (MULTIPLE SCLEROSIS, STROKE, ETC.)			
PSYCHIATRIC (ANXIETY, DEPRESSION, ETC.)			
ENDOCRINE (DIABETES, HYPOTHYROID, ETC.)			
BLOOD/LYMPH (ANEMIA, ETC.)			
ALLERGIC/IMMUNOLOGIC (HAY FEVER, LUPUS, SJOGRENS, ETC.)			

FAMILY HISTORY

DISEASE	**YES**	**NO**	**RELATIONSHIP TO PATIENT**
BLINDNESS			
CATARACTS			
GLAUCOMA			
RETINAL DISEASE			

SOCIAL HISTORY

CURRENT OCCUPATION: _____

MARITAL STATUS: _____

DO YOU SMOKE? ☐ YES ☐ NO HOW MANY PACKS PER DAY? _____

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ☐ YES ☐ NO

Jeffrey Y.H. Chung, M.D.
14201 Laurel Park Drive
Suite 104
Laurel, MD 20707

PATIENT ACKNOWLEDGEMENT/CONSENT FORM

Use & Disclosure of
Protected Health Information

The "Notice of Privacy Practices" of Jeffrey Yau Huei Chung, M.D. provides information about how we may use and disclose protected health information about you. By signing below, you acknowledge receipt of this office's Notice of Privacy Practices. Our Notice of Privacy Practices states that we reserve the right to change the terms described.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Jeffrey Y.H. Chung, M.D. for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

_____

SIGNATURE OF PATIENT/REPRESENTATIVE **DATE**

Jeffrey Y.H. Chung, M.D.
14201 Laurel Park Drive
Suite 104
Laurel, MD 20707

PATIENT FINANCIAL TERMS AND CONDITIONS

We are committed to providing you with the best possible medical care and service. If you have health insurance, we will send in your claims for you to receive the maximum allowable benefits. Please give us the most up to date health insurance at the beginning of each appointment. There are many insurances and your insurance is a contract between you and your insurance company, so we ask that you take the time to review and understand your benefits, as they may change. If you are using anything other than a health insurance policy that is in good standing, you will be responsible for all charges not covered.

Patients are to be responsible for any portion of charges the insurance company does not cover, such as co-pay, deductible, or a co-insurance percentage. Payment is expected at the time services are rendered. Please provide ALL active health insurances you have. Patients are responsible for all charges that are unpaid from insurance company due to lack of disclosure of their primary/secondary or other insurances.

Acquiring referrals from your primary care is the patient's responsibility. If your insurance requires a specialist referral, please ensure it is sent to the office prior to your visit. Patients will be responsible for any charges that are unpaid from the insurance company due to lack of referral.

Patients without health insurance, charges for examination and procedures will be discussed with you and are due upon time of service.

Appointments are reserved exclusively for you, so if an appointment cannot be kept, please give at least 24 to 48 hours notice. Missed and cancelled appointments made on same day will be subjected to a fee. If your outstanding balance (120 days past due), is sent to the collection agency, it may negatively affect your credit rating. Please try to avoid this by paying promptly.

Please be aware that medical records and reports do take significant time and resources. Patients are responsible for all applicable fees. A fee may be charged for all forms filled out including driver license forms. If you have an outstanding balance with the office, you must resolve your account before paperwork requests will be processed. We ask that you give us ample time (at least 2 weeks) to complete these requests.

By my signature, I indicate that I have read, understand and do hereby accept the terms of this agreement.

_____

SIGNATURE OF PATIENT/REPRESENTATIVE DATE

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INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Jeffrey Y.H. Chung and/or such assistants as may be designated by him to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____

Patient (or person authorized to sign for patient) Date