

Advanced Eyecare of Orange County/ Kim T. Doan, M.D.

351 Hospital Rd #100, Newport Beach, CA 92663
19582 Beach Blvd #310, Huntington Beach, CA 92648

Phone: 949.645.6300
Phone: 714.965.0300

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with care and service that you expect and deserve. Achieving your **best possible health** requires a “partnership” between you and your doctor. As our “partner in health,” we ask you to help us in the following ways:

Schedule Visits with Dr. Doan for Recommended Yearly Eye Exams, Glaucoma/Diabetic/Hypertensive/High Risk Medication Screenings and other Recommended Eye Screenings

I understand that Dr. Doan will explain to me which regular eye screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (diabetic eye exam, glaucoma/cataract/macular degeneration screening, high risk medication screening, etc). **These screenings are tests/exams that can help detect vision threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular ophthalmologic screenings, I put myself at risk of letting serious eye problems go undetected. I will schedule regular visits with my doctor to complete my yearly ophthalmologic eye exams.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know about how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious eye condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious eye condition. I will make every effort to reschedule missed appointments as soon as possible.

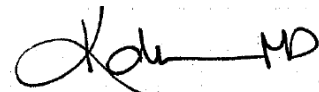
Call the Office When I Do Not Hear the Results of Tests

I understand that my physician's goal is to report test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *NOT* to Follow Her Recommended Treatment Plan

I understand that after examining me, my Dr. Doan may make certain recommendations based on what she feels is the best for the health of my eyes. This might include prescribing medication, referring me to specialist, ordering tests or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my eyes. I will let Dr. Doan know whenever I decide *not* to follow her recommendations so that she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your eye condition, please ask or visit our website at www.kimdoanmd.com.



Patient Signature

Date

Physician Signature

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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: _____

Email address: _____

Driver License No.: _____ Social Security No.: _____ - _____ - _____

Employer Name: _____ Occupation: _____

Business Address: _____ Work Phone: (____) _____

City, State: _____ Zip: _____

Spouse Name: _____ Phone: (____) _____

Spouse's Business/Address Name: _____ Occupation: _____

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: _____/_____/_____

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PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

The Right to be treated with respect and dignity.

The Right to make treatment choices.

The Right to refuse treatment.

The Right to obtain medical records.

The Right to informed consent in language understood.

The Right to make decisions about end-of-life care.

The Right to exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation or marital status or the source of payment for care.

Patient Responsibilities

Maintain healthy habit

Be respectful to provider

Be honest to provider

Comply with treatment plan

Make decisions responsibly

Understand prescription drugs and possible side effects

Meet financial obligations

Avoid putting others at risk

Patient's Signature _____ Date: ____ / ____ / ____

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ELIGIBILITY WAIVER

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

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

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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 (*this is available on our website at www.kimdoanmd.com*)

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: _____

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 ALL medications you are taking, including eye drops. <input type="checkbox"/> I am not currently taking any medications	
2. Do you have any allergies to any medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Constitutional (fever, weight loss, other)	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Eyes (glaucoma, cataract, lazy eye, retina problems, other - please specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No Previous eye lasers/surgery/injury?
5. Ear / nose / mouth / throat (hearing loss, sinus problems, sore throat)	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Cardiovascular (heart problems, chest pain, irregular heartbeat, HYPERTENSION)	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Respiratory (asthma, shortness of breath, wheezing, coughing)	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Gastrointestinal (heartburn, abd. pain, diarrhea, vomiting)	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Genitourinary (urinary problems, blood in urine)	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Integumentary (skin rashes, excessive dryness)	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Musculoskeletal (muscle aches, joint pain, swollen joints)	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Neurological (numbness, weakness, headaches, paralysis)	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Hematologic/Lymphatic (blood disorders, leukemia)	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Allergic/Immunologic (hay fever, allergies)	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Endocrine (thyroid problems, DIABETES, ELEVATED CHOLESTEROL/LIPIDS)	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Psychiatric (depression, anxiety)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Family history: Do any eyediseases 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? _____

Do you wear Glasses? Y / N
 Do you wear Glasses to Drive? Y / N
 Have you received an Influenza Vaccine? Y / N
 Have you received a Pneumococcal Vaccine? Y / N

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: _____