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

355 Placentia Ave #305 Newport Beach, CA 92663 Phone: 949.645.6300
19582 Beach Blvd #310, Huntington Beach, CA 92648 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.

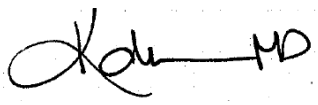
Call the Office When I Do Not Hear the Results of Tests

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 if 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/AfricanAmerican ☐ 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 RESPONSIBILITES

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 Responsibilites

Maintain healthy habits

Be respectful to providers and staff

Be honest to providers

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

Do you smoke? Y☐ / N☐
If yes, how much?_____

Drink alcohol? Y☐ / N☐
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 Pneumoccal 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***: _____