KEW GARDENS
FAMILY EYECARE

DR. JENNIFER CHIN & DR. STEPHEN DONG
8002 Kew Gardens Rd C-108, Kew Gardens, NY 11415
Telephone: (718) 544-2222 Fax: (718) 544-7350

Personal Information:

Name (Last, First): _____ Preferred Name: _____

DOB: _____ / _____ / _____ Age: _____ Sex: ☐ M ☐ F ☐ Other Social Security No.: _____

Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip Code: _____

Preferred Contact Number: ☐ Home:_____ ☐ Mobile: _____

Email Address: _____@ ☐ gmail.com ☐ yahoo.com ☐ hotmail.com ☐ Other: _____

Marital Status (check one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Employment Status (check one): Occupation:_____

☐ Full Time ☐ Part-Time ☐ Retired ☐ Unemployed ☐ Part-Time Student ☐ Full-Time Student

Additional Contact Information:

General Physician's Name: _____ Telephone Number: _____

Referred By: _____ Telephone Number: _____

Emergency Contact: _____ Telephone Number: _____

Insurance and Payment Information:

Preferred Method of Payment: ☐ Cash ☐ Visa/Mastercard ☐ Amex ☐ Other

INSURANCE COVERAGE: We are a provider for a number of managed vision care plans. If you have one of these plans, we will gladly accept assignment. If you do not, we will fill out any forms you need for reimbursement.

Vision Care Insurance Plan: _____ ID: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse/Significant Other ☐ Child

Health Insurance Plan: _____ ID: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse/Significant Other ☐ Child

PLEASE READ, SIGN AND DATE

FOR PATIENTS WITH MANAGED CARE OR VOUCHER PLANS: I hereby assign my insurance benefit to be paid directly to Dr. Stephen Dong and Dr. Jennifer Chin. I understand that I will be responsible for any deductible or co-payments. If my insurance is denied, I will be responsible for all usual and customary fees. I understand that my vision plan may not cover all examinations, tests and treatments that the doctor deems necessary or advisable.

If I decline these items or choose to go elsewhere through other coverage, I will not hold Dr. Stephen Dong and Dr. Jennifer Chin liable for any damages due to my delay in seeking treatment.

FOR ALL PATIENTS: If my account must be turned over for collection, I will also be responsible for all interest and collection fees.

Signature: _____ **Today's Date:** _____ / _____ / _____

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Health Information:

Many diseases of the body have serious health consequences. For example, diabetes is one of the leading causes of blindness. Therefore, it is important that we acquire an in-depth medical history. Please answer the following questions. While they may seem unrelated to an eye problem, it is crucial to your care that we ask them. This information is also critical in the event we need to prescribe certain medications.

Date of last eye exam: _____ / _____ / _____

Do you wear glasses? ☐ Yes ☐ No Approximately how old is your current pair: _____

Do you wear contact lenses? ☐ Yes ☐ No Approximately how old is your current pair: _____

Do you work on a computer? ☐ Yes ☐ No Approximately how many hours a day: _____

Are you currently experiencing any of these ocular symptoms (check all that apply):

☐ Itching ☐ Burning ☐ Tearing ☐ Dryness ☐ Flashes
☐ Floaters ☐ Vision Change ☐ Total Vision Loss ☐ Redness ☐ Pain
☐ Double Vision ☐ Headaches

Personal Eye History (check all that apply):

☐ Previous Eye Injury ☐ Dry Eyes ☐ Retinal Detachment
☐ Previous Eye Surgery ☐ Cataracts ☐ Floaters
☐ Glaucoma ☐ Macular Degeneration

Family Eye History (check all that apply):

☐ Glaucoma Family Relationship: _____
☐ Cataracts Family Relationship: _____
☐ Macular Degeneration Family Relationship: _____
☐ Retinal Detachment Family Relationship: _____

Personal Medical History:

Date of last medical exam/physical: _____ / _____ / _____

1. Are you currently under the care of a physician? ☐ Yes ☐ No
   If yes, why? _____
2. Are you taking any prescribed or over the counter medications? ☐ Yes ☐ No
   If yes, please list all medications: _____
3. Are you allergic to any medications? _____
4. Do you smoke cigarettes? ☐ Yes ☐ No If yes, how many per day: _____
5. Do you consume alcohol? ☐ Yes ☐ No If yes, how many glasses per day: _____

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Health Information cont.

Do you have or have you ever been informed that you had any of the following (check all that apply):

☐ **Diabetes**	☐ **High Cholesterol**	☐ Asthma/Hay Fever	☐ Sinus Trouble
☐ Heart Disease	☐ Thyroid Issues	☐ Headaches/Migraines	☐ Tuberculosis
☐ Arthritis	☐ Lung Problems	☐ Persistent Cough	☐ AIDS
☐ **High blood pressure (Hypertension)**		☐ Skin Disease	☐ HIV Disease
☐ Lyme Disease	☐ Allergies/Hives	☐ Cancer or Leukemia	☐ Multiple Sclerosis
☐ Sickle Cell Disease	☐ Stroke	☐ Sarcoidosis	☐ Lupus

☐ Tuberculosis ☐ Sexually Transmitted Disease (Gonorrhea, Syphilis, Genital Herpes)

☐ OTHER _____

COVID-19 Questionnaire:

For your safety, the safety of the staff and future patients, please answer the following questions:

1. Have you or someone in close proximity to you had a fever within the last 14 days? ☐ Yes ☐ No
2. In the last 14 days, have you been in close contact with a confirmed or possible COVID-19 person? ☐ Yes ☐ No
3. Have you traveled in the last 14 days?: ☐ Yes ☐ No
   If yes, where? _____
4. Have you experienced any cold or flu-like symptoms in the last 14 days ☐ Yes ☐ No
   (includes fever, cough, sore throat, respiratory illness, or difficulty breathing)?
5. Have you been fully vaccinated for COVID-19? ☐ Yes ☐ No

Patient Acknowledgement of Receipt of Privacy Practices Notice

The *Notice of Privacy Practices* is attached below. Please carefully review the *Notice of Privacy Practices* and once you are done, sign at the bottom of this document.

I, _____, hereby acknowledge that I have received and reviewed a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

You may also contact the secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services

Patient or Personal Representative

Signature: _____ **Today's Date:** _____ / _____ / _____

Name: _____

Relationship to Patient: _____