Jon L. Yang, M.D. & David S. Yee, M.D.

Date 日期: _____

Patient Information (PLEASE PRINT ANSWERS) 個人資料 (請用正楷填寫)

Name: Last 姓名	First	Middle	Date of Birth 出生日期	Age 年齡

Sex: M/F 性別: 男/ 女	Social Security# 工卡號碼	Home Phone 住家電話	Cell Phone 手機號碼

Street Address 住址	City	State	Zip Code

Name of Emergency Contact 緊急聯絡人	Relationship 與你的關係	Their Phone Number 他們的電話號碼

Insurance Information. Please list all information.
醫療保險資料. 請填寫所有問題.

Primary Medical Insurance 主醫療保險	Name of Policy Holder 保險持有人	DOB of Policy Holder 保險持有人出生日期

Name of Subscriber 保險用戶姓名	Date of Birth of Subscriber 保險用戶出生日期

Primary Care Physician 主診醫生	Phone Number 主診醫生電話號碼

Secondary Medical Insurance 副醫療保險	Vision Insurance 眼科保險

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Eye History

1.What is the reason for your office visit today? Please describe the main problems with your eyes. 你今天看楊/余醫生的原因是甚麼? 請說明.

_____

_____

2. Do you wear glasses? Yes/No 你戴眼鏡嗎? 有/無

If Yes, do you wear (circle all that apply): distance glasses/reading glasses/bifocals/progressives? 如果你戴眼鏡, 你戴近視眼鏡, 老花眼鏡, 雙光眼鏡或漸進式眼鏡? (請圈示)

3. Do you wear contact lenses? Yes/No What brand? _____
你戴隱形眼鏡嗎? 有/無 甚麼牌子?_____

4. When was your last eye or vision exam? Where and why were you seen?
你上次看眼科醫生是甚麼時候? 在哪裡和是因為甚麼原因?

_____

_____

5. Do you have the following: 你有以下的症狀嗎?

Blurred or reduced vision? Yes/No 眼睛模糊或視力下降? 有/無
Eye pain? Yes/No 眼痛? 有/無
Eye itching? Yes/No 眼睛癢? 有/無
Eye tearing? Yes/No 眼睛流眼水? 有/無
Eye crusting or discharge? 眼睛結痂或有分泌物? 有/無
Flashes of light? Yes/No 眼睛見到閃電? 有/無
Floaters? Yes/No 眼睛見到浮子? 有/無
Eye surgery? Yes/No 眼睛的手術? 有/無

If Yes, when and what type of eye surgery? _____
如果有做過眼睛的手術, 那是什麼手術和在甚麼時候? _____

Eye injury? Yes/No 眼睛受傷? 有/無
Glaucoma? Yes/No 青光眼? 有/無
Cataract? Yes/No 白內障? 有/無
Other eye problems? Yes/No 其他的眼睛問題? 有/無

If yes, what type of other eye problems? _____
如果有其他的眼睛問題, 那是甚麼問題? _____

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Current eye drops or ointments. Please list them.現在你正在用的眼藥水或眼藥膏. 請列明.

1. _____
2. _____
3. _____
4. _____
5. _____

What is the address and phone number of your pharmacy?
你的藥房地址和電話

_____

Medical History

1. Do you have any drug allergy? Yes/No
   If Yes, what drug allergy? _____
   你有藥物過敏嗎? 有/無　如果有,是甚麼藥物? _____
2. Do you have diabetes? Yes/No 你有糖尿病嗎? 有/無
3. Do you have hypertension? Yes/No 你有高血壓嗎? 有/無
4. Do you have high cholesterol? Yes/ No 你有高膽固醇嗎? 有/無
5. Do you have thyroid disease? Yes/No 你有甲狀腺疾病嗎? 有/無
6. Do you smoke? Yes/No 你抽菸嗎? 有/無
7. Do you drink alcohol? Yes/No 你喝酒嗎? 有/無
8. Is there any family history of the following? 你有以下的家庭病史嗎?
   Cataract? Yes/No 白內障? 有/無
   Glaucoma? Yes/No 青光眼? 有/無
   Retinal Problems? Yes/No 視網膜問題? 有/無
   Blindness? Yes/No 眼瞎? 有/無
   Hereditary or family diseases or conditions? Yes/No 其他遺傳或家族病? 有/無
   Other family eye problems? Yes/No 其他家族眼病? 有/無
   If yes, what other family eye problems? _____

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Authorization to Release Medical Record

I agree and authorize the office of Dr. Jon L. Yang and Dr. David S. Yee to release my medical information upon the request of my insurance company, my primary care physician, other physicians I see or other agencies for determining my insurance coverage and benefits, to further assist in my medical care by other physicians and for services I receive from other agencies.

醫療資料授權書

我同意並准許楊仲倫或余純光醫生在我的醫療保險, 家庭醫生, 其他醫生或其他機構的要求下提供我的病歷資料以方便決定我的醫療保障, 幫助我所看的醫生對我的療理及我在其他機構申請的服務.

Patient Signature and/or legal guardian and Date: _____
病人或監護人簽名及日期: _____

Financial Agreement

The office of Dr. Jon L. Yang and David S. Yee will submit a request for payment on your claim to your designated insurance carrier and/or company. However, in the event that your insurance carrier and/or company denies your claim, or the services are applied to your deductible, you will be responsible for all professional charges in full. By signing this agreement, you are assuming responsibility of all unpaid charges.

I have read, understand, and agree to the above financial statement. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

付款同意書

楊仲倫醫生和余純光醫生會先向你的保險公司要求支付你的診金. 如果你的保險公司不支付或拒絕支付你的診金或你的保險上有自付額, 你將會需要完全負責支付你的診金. 簽這同意書, 你同意負責所有沒有支付的款項.

我已經閱讀, 明白和同意以上的付款協議. 我明白我將要負責支付我保險公司不支付的診金, 我保險上的掛號費和自付額.

Patient and/or legal guardian Signature and Date: _____
病人或監護人簽名及日期: _____

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Pupil Dilation Informed Consent

Pupil dilation is very commonly done to enable a complete eye exam. This technique allows the doctor to observe the peripheral area of the retina that would otherwise be hidden from view and also to detect other eye problems.

Pupil dilation is accomplished through the use of eye drops. The effects of the eye drops will last from 3 to 5 hours, but may be longer. Your near vision will become blurred, and you will also be sensitive to light. Your distance vision will usually not be blurred, but may seem a little distorted. You will be given a pair of sunglasses after the dilation upon request. You are allowed to drive if desired after the dilation, but you should use extra caution, and this applies to all other physical activities as well.

Complications from dilation are extremely rare. If you experience any unusual pain or discomfort after the dilation, please contact our office immediately. The doctor, staffs, or office will not be held liable for any accidents or injuries affecting the patient while dilated, and you have the right to refuse dilation as well as any other medical procedures provided by our office.

I hereby agree to have my eyes dilated.

Patient Signature and Date: _____

瞳孔扩大同意書

瞳孔扩大是一種可以幫助眼科醫生做全面眼睛檢查所使用的普遍技術. 這種技術能使醫生清楚的檢驗 视网膜的周邊及發現其他的眼睛問題. 瞳孔扩大是用眼藥水完成的. 眼藥水的效果會是三至五個小時或更長.你近距離的視力會變模糊和你會變得有些怕光. 你遠距離的視力通常不會變得模糊, 但是可能會變得有一點扭曲. 我們診所會在你瞳孔扩大後和要求下給你一副暫時性的太陽眼鏡. 瞳孔扩大後, 大部分的人都可以正常的開車 , 但是你需要特別的小心, 做其他活動的時候也是.由瞳孔扩大而所引起的并发症是非常少見的. 如果你在瞳孔扩大後有任何的疼痛或不適請立刻通知我們的診所. 我們的醫生, 員工或診所將不會為瞳孔扩大後所發生的受傷或車禍事故負上任何法律责任. 你有權拒絕瞳孔扩大及我們診所所提供的其他醫療服務.

我在此同意醫生扩大我的瞳孔.

病人簽名及日期: _____

Jon L. Yang, M.D. & David S. Yee, M.D.

Patient Name:_____
DOB: _____

Authorization to Release Medical Record

I agree and authorize the office of _____ to release my medical information to the office of Dr. Jon L. Yang and Dr. David S. Yee to further assist in the medical care that I receive from of Dr. Jon L. Yang and Dr. David S. Yee.

醫療資料授權書

我同意並准許_____向楊仲倫或余純光醫生提供我的病歷資料以幫助楊仲倫或余純光醫生對我的療理。

Patient Signature and/or legal guardian and Date: _____
病人或監護人簽名及日期: _____