BETHEL EYE CENTER
266 S. Harvard Blvd., Suite 500
Los Angeles, CA 90004
(213) 739-6900

Today's Date:_____

PATIENT INFORMATION

Last Name (성):	First Name (이름):	Birthday (생일):

Marital status: Married [ ] Single [ ]	Sex (성별): M (남) F (여)	Cell Phone (핸드폰): Home Phone (집):

Residence address (거주주소):

	Social Security number:
City(시) Zip	E-Mail:

If Child, Parent's name or guardian's name (보호자 성함):
_____ _____

Emergency Contact: (응급시 연락처)
Name (이름): _____ Cell Number (핸드폰): _____

Whom may we thank for referring you? (소개해 주신 분):
Personal physician (주치의):
Your Pharmacy (약 국): City: Phone Number:

Chief eye Complaint? (눈이 어떻게 불편하신가요?)

Allergies (알러지):

치료하는데 약물 알러지가 있습니까?
( ) 아니요 ( ) 페니실린 ( ) 설파 ( ) 기타 _____
다음 중 해당되는 알러지가 있습니까?
( ) 음식물 ( ) 라텍스 ( ) 의약품 ( ) 환경 ( ) 요오드 ( ) 기타 _____

Do you have any allergies to medications? Circle all that apply – ( ) none ( ) Penicillin ( ) Sulfa ( ) other:_____
Do you have any of the following allergies? ( ) Latex ( ) Iodine ( ) Food_____ ( )other:_____

Authorization & Acknowledgment

MEDICAL AUTHORIZATIONS AND RELESE OF INFORMATION

I hereby authorize Bethel Eye Center to furnish the insured's insurance company all information which said the insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the services performed. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible for all charges, I hereby authorized Bethel Eye Center to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. This authorization shall continue and remain effective until revoked in writing by me.

AUTHORIZATION FOR RELEASE OF INFORMATION

The signature below serves as authorization for Bethel Eye Center to release or receive medical information for the purpose of patient referral. A copy of this signature is as valid as the original.

ACKNOWLEDGEMENT

Refraction Policy - Refraction is the process of determining the eyes refractive error, or need for corrective spectacle and/or contact lenses. It is an essential part of an eye examination, but is not a covered service by Medicare or most insurance. A fee for the refraction will be collected in addition to any co-payment or deductible.
I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The co-payment is separate from and not included in the refraction fee. Routine Examination – Most medical insurance plans, including Medicare, DO NOT COVER routine eye examinations when no medical eye problem is known or suspected. This office DOES NOT SUBMIT routine eye examinations for insurance reimbursement without prior authorization. If your exam today is routine, you may be responsible for payment. Contact Lens Agreement – We are happy to assist you with any contact lens issues you may have. However, we a medical practice and your medical insurance does not cover any services related to contact lenses. Contact lens evaluations, fittings, etc. are considered over and above a regular eye exam. Therefore, additional charges related to contact lenses would be your responsibility.

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. Pak and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

동공확대 안약 투여에 관한 공지사항

동공 확대약은 안과전문의가 환자의 눈 안쪽을 더 자세히 보기위하여 눈의 동공을 확장하는데 사용됩니다. 동공확대약을 투여한 후 얼마동안 시력이 침침하게 되며 (환자마다 동공확대 소요 시간이 더 길 수 있음) 밝은 빛에 눈부심, 조절장애로 인한 시력저하 등이 발생하게 됩니다. 동공확대 안약이 환자분의 시력에 어느정도까지 영향을 미칠지를 미리 예측하기는 불가능합니다. 동공확대 후에는 운전하시기 어려움이 있을 수 있으니, 내원시 대중교통을 이용하거나 대리인에게 운전을 맡기시도록 미리 조처하는 것이 안전을 위해 최상책임을 알려드립니다. 또한 동공확대 후에는 눈부심이 발생하게 되므로 썬글래스, 모자 등을 미리 준비하시면 도움이 될 수 있습니다. 동공확대 안약 투여 후에 안구통증이나 두통이 발생한 경우에 안과로 즉시 연락 주셔야 합니다. 동공확대로 인해 급성 녹내장이 발생할 수 있으며 오래 방치할 경우 치료가 어렵게 됩니다. 동공확대 후에는 안경검사(굴절검사)가 불가능하니, 안경검사를 같은 날 계획하신 분은 미리 말씀해주십시요. 벧엘 안과를 찾은 환자로서 동공확대 투여가 저의 눈 상태를 진단하는데 필수적임을 인식하기에, 이곳에서 일하는 의사 (Dr.Pak)혹은 의료 직원이 저의 눈에 동공확대 약을 투여하는 것을 허락합니다.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have reviewed the Bethel Eye Center Privacy Practice that describes how information about me may be used and disclosed. At my request, I can receive a copy of this notice. I certify that all statements given to the Bethel Eye Center are complete and accurate to the best of my knowledge.

I Certify that all statements given to Bethel Eye Center are complete and accurate to the best of my knowledge.

X_____ _____ Date: _____
Patient/Guarantor Signature

X_____ __ Date: _____
Physician's Representative Signature