ITALI EYE CARE

PATIENT INFORMATION (환자정보)

Last Name (성): _____ First Name (이름): _____ Sex (성별): M (남) / F (여)

DOB (생년월일): _____/_____/_____ SSN (소셜번호): _____-_____-_____ Email (이메일): _____

Primary Phone (집전화): _____ Secondary Phone (휴대전화): _____ Occupation (직업): _____

Address (주소):_____
(Street) (City) (State) (Zip Code)

Marital Status (결혼상태): _____ Primary Care Physician (주치의): _____ Last Medical Exam (최근 의료검사일): ___/___/_____

VISION INSURANCE (안과보험)

Insurance Name(보험회사명): _____ Insurance ID #(보험 ID): _____ Group #(그룹번호): _____

Policy Holder's Name(주가입자): _____ Policy Holder's Relationship to Patient(주가입자와의 관계): _____

Group Name/Employer(그룹이름/고용주): _____ Policy Holder's DOB(주가입자생년월일): _____/_____/_____

MEDICAL INSURANCE (의료보험)

Primary Insurance Name(보험회사명): _____ Insurance ID #(보험 ID): _____ Group #(그룹번호): _____

Policy Holder's Name(주가입자): _____ Policy Holder's Relationship to Patient(주가입자와의 관계): _____

Group Name/Employer(그룹이름/고용주): _____ Policy Holder's DOB(주가입자생년월일): _____/_____/_____

Do you have Secondary Medical Insurance (2 차의료보험이 있습니까) ? Yes(네) / No (아니요) Name of Secondary Insurance(2 차의료보험명):_____

FINANCIAL RESPONSIBILITY: I certify that the above information is correct. I understand that payment is due in full at the time the services are rendered, including follow-up office visits related to my eye conditions and any non-covered services, co-payments, and deductibles. In the event that my vision/health plan determines that a service is not covered and denies payment for any reason, I understand that I am financially responsible for the complete charge. If my insurance company has not reimbursed Itali Eye Care, I may be billed for any services or products that I have received. If insurance benefits are being utilized for services, I hereby authorize direct payment of my vision and/or medical benefits to Itali Eye Care. I authorize the release of any medical or other information necessary to process my insurance claims. I understand that my signature recognizes my financial responsibilities and will be used only for those insurance plans that Jane Kim, O.D. at Itali Eye Care is a participating provider for.

나는 위의 내용이 사실임을 증명합니다. 나는 이태리 안경에서 받은 진료 및 모든 치료에 대해 이태리 안경이 보험회사에 청구하는것에 동의합니다. 또한 보험에 적용되지 않는 부분은 환자 본인이 부담하는것에 동의합니다. 필요한 경우 이태리 안경이 환자 본인의 진료 기록 및 관련내용을 다른 의료기관이나 보험회사들과 공유하는것에 동의합니다.

CONSENT FOR TREATMENT: I hereby authorize Dr. Jane Kim to examine and administer diagnostic and medical procedures as deemed necessary for proper health care.
진료동의: 나는 김제인 검안의가 진료하고 치료하는것에 동의합니다.

HIPAA ACKNOWLEDGEMENT: I hereby authorize Itali Eye Care to release any medical, incidental, or contact information that may be necessary to conduct treatment, to process insurance claims for payment of rendered services, to refer to another provider for further care, to send reminders for future appointments (via phone, text, paper mail, or email), and to process applications for other services (driver's license, rehabilitation, social security, disability, worker's compensation). I understand that my protected information can also be released to specific party or person(s) with written authorization. I have been offered a copy of Itali Eye Care's Notice of Privacy Practices. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information.
이태리 안경은 개인정보 보호 관행통보령(HIPAA)을 준수합니다.

OPT-IN FOR EMAIL & TEXT MESSAGES: I hereby authorize Itali Eye Care to contact me through email and text, and understand that these messages are not limited to appointment reminders and promotions. I understand that I may opt-out at any time by emailing italieyecare@gmail.com or via text.

SIGNATURE(서명): _____ **Date(날짜):** _____/_____/_____

Name and Relationship to Patient (if other than patient) (이름 및 환자와의 관계 – 본인이 아닐 경우): _____

Date of Last Eye Exam(**최종검안일자**): _____/_____/_____ Age of current glasses(**현재안경사용기간**): _____

Have you ever worn *contact lenses*? Yes / No
(**컨텍렌즈를 사용해 보신적이 있습니까**) (네) / (아니오)

If yes, what *type/brand* of contact lenses?: _____
(**사용하신다면 어떤종류/브랜드의 렌즈입니까**)

Have you had any eye or head *injuries*? Yes / No
(**눈이나 머리를 다친 적이 있습니까**) (네) / (아니오)

If yes, explain: _____
('네'인 경우 설명하세요)

Have you had any eye *surgeries*? Yes / No
(**눈수술을 받은적이 있습니까**) (네) / (아니오)

If yes, explain: _____
('네'인 경우 설명하세요)

Do you *smoke*? Yes / No
(**흡연하시나요**) (네) / (아니오)

Did you *ever smoke*? Yes / No
(**흡연하신적이 있나요**) (네) / (아니오)

If you've *quit*, how long ago?_____
(**끊었다면 언제입니까**)

Do you *drink*? Yes / No
(**음주하시나요**) (네) / (아니오)

If Yes, how many *drinks/week*? _____
(**만약하신다면 주중 음주량은**)

Do you use any *recreational drugs*? Yes / No
(**향정신성의약품을 사용하십니까**) (네) / (아니오)

VISUAL HISTORY: Have ***you*** had any of these problems or currently experience any of these problems?

(**시력 기록**: 과거 또는 현재에 하기 해당사항이 있으면 'Yes', 없으면 'No' 표기 하세요)

	Yes	No		Yes	No		Yes	No
Blurred Vision at Distance (원거리흐리게보임)	☐	☐	Sandy or Gritty Eyes (이물감)	☐	☐	Glare/Light Sensitivity (반사/빛예민감)	☐	☐
Blurred Vision at Near (근거리흐리게보임)	☐	☐	Excess Watering (과잉눈물)	☐	☐	Flashes of Lights (섬광보임)	☐	☐
Headaches (두통)	☐	☐	Dry Eyes (건조증)	☐	☐	Floaters (비문증/날파리증)	☐	☐
Eyestrain (눈피로)	☐	☐	Eye Pain/Soreness (눈통증)	☐	☐	Double Vision (이중시력)	☐	☐
Burning (눈따가움)	☐	☐	Frequent Styes (빈번한눈병)	☐	☐	Loss of Vision (시력상실)	☐	☐
Itching (가려움)	☐	☐	Red/Pink Eye(s) (결막염)	☐	☐	Prosthetic Eye (인공안구)	☐	☐

OCULAR & MEDICAL HISTORY: Please indicate any ***personal*** or ***family*** history (parents, grandparents, siblings, children).

(**시력및 병력**: 개인이나 가족의 병력을 표기해 주세요 – 부모, 조부모, 형제, 자매, 자녀)

	Self	Family	None		Self	Family	None
Glaucoma (녹내장)	☐	☐	☐	Diabetes (Type 1 / 2) (당뇨)	☐	☐	☐
Cataracts (백내장)	☐	☐	☐	High Blood Pressure (고혈압)	☐	☐	☐
Retinal Detachment (망막 박리)	☐	☐	☐	High Cholesterol (콜레스테롤)	☐	☐	☐
Macular Degeneration (황반변성증)	☐	☐	☐	Thyroid Disease (갑상선질환)	☐	☐	☐
Crossed/Lazy Eye (사시/약시)	☐	☐	☐	Cancer (암)	☐	☐	☐
Blindness (실명)	☐	☐	☐	Stroke (뇌졸증)	☐	☐	☐
Uveitis / Iritis (포로막염/홍염)	☐	☐	☐	Arthritis (관절염)	☐	☐	☐
Keratoconus (원추각막)	☐	☐	☐	Breathing Problems (호흡곤란)	☐	☐	☐

REVIEW OF SYSTEMS: Please indicate any conditions ***you*** currently have.

(**신체검토**: 현재 신체 상태를 표기하세요)

CONSTITUTIONAL (전신)	Yes	No
Fever (열)	☐	☐
Fatigue (피로감)	☐	☐
Weight Gain or Loss (몸무게변화)	☐	☐
Developmental Disability (발육성장애)	☐	☐

GASTROINTESTINAL (위)	Yes	No
Nausea / Vomiting (구토)	☐	☐
Changes in Bowel Movements (배변변화)	☐	☐

ALLERGIC/IMMUNOLOGIC (알레르기/면역)	Yes	No
Environmental Allergies (알레르기)	☐	☐
Graves Disease (그레이브스 병)	☐	☐

GENITOURINARY (비뇨생식기)	Yes	No
Kidney Disease (신장병)	☐	☐
Prostate Disease (전립선병)	☐	☐
Sexually Transmitted Infections (성병)	☐	☐

NEUROLOGICAL (신경)	Yes	No
Headaches / Migraines (두통/편두통)	☐	☐
Seizures / Epilepsy (발작/간질)	☐	☐
Multiple Sclerosis (다발성경화증)	☐	☐
Cerebral Palsy (뇌성마비)	☐	☐
Brain Tumor (뇌종양)	☐	☐

EAR/NOSE/THROAT/MOUTH (귀/코/목/입)	Yes	No
Dizziness (어지럼증)	☐	☐
Dry Mouth / Throat (건구증)	☐	☐
Sinusitis (비강염)	☐	☐
Hearing Loss (청력상실)	☐	☐

RESPIRATORY (호흡기)	Yes	No
Asthma (천식)	☐	☐
COPD (만성폐쇄성폐질환)	☐	☐
Shortness of Breath (호흡곤란)	☐	☐
Sleep Apnea (수면무호흡증)	☐	☐

CARDIO/VASCULAR (심장/혈관)	Yes	No
Heart Disease (심장병)	☐	☐
Vascular Disease (혈관질환)	☐	☐
Chest Pain (가슴통증)	☐	☐
Stroke (뇌졸증)	☐	☐

BONES/JOINTS/MUSCLES (뼈/관절/근육)	Yes	No
Ankylosing Spondylitis (강직성 척추염)	☐	☐
Fibromyalgia (섬유근육통)	☐	☐
Muscular Dystrophy (근육위축증)	☐	☐

SKIN (피부)	Yes	No
Atopic Dermatitis (아토피성 피부염)	☐	☐
Rosacea (주사비)	☐	☐
Dermatitis (Eczema) (피부염)	☐	☐
Psoriasis (건선)	☐	☐

BLOOD/LYMPH (혈액)	Yes	No
Anemia (빈혈)	☐	☐
Bruising/Bleeding Problems (멍 또는 출혈)	☐	☐

PSYCHIATRIC (정신과)	Yes	No
ADD / ADHD (주의력결핍/과다행동장애)	☐	☐
Depression (우울증)	☐	☐
Anxiety (불안증)	☐	☐

Other (기타): _____

_____

[**Are you Pregnant or Nursing?** Yes / No]
(임신중이거나 수유중입니까? 네 / 아니오**)**

List any allergies to medications or other substances (알레르기 반응있는 약물이나 의약품을 나열 하세요):

_____

List medications you take (prescription medications, over-the-counter medications, eye drops, home remedies)
(복용중인 약을 나열하세요 – 처방약, 일반약, 안약, 민간요법 포함):

_____

_____

DILATION OF PUPILS (동공확장 – 눈의 건강상태 진료)

Health and ocular problems such as glaucoma, cataracts, retinal tears, diabetes, high blood pressure, and some tumors may be detected even before the onset of symptoms or loss of vision. Dr. Jane Kim highly recommends dilated eye exams. This procedure will temporarily result in blurred vision and sensitivity to light for about 3-5 hours. If needed, sunglasses will be provided. Many insurance plans include dilation as a covered benefit. Without insurance, the procedure is an additional $20.00. If you feel uncomfortable driving after this procedure, you may return at a later date with a driver. Please check *one* of the following options:

녹내장, 백내장, 망막박리, 당뇨, 고혈압과 암같은 건강상 문제는 증상이 발견되거나 시력을 상실하기전에 발견될수 있습니다, 닥터 제인김은 동공확장 검사를 추천합니다. 이 검사는 일시적으로 흐리게 보이거나 3~4 시간동안 빛에 민감하게 반응할수 있습니다.. 필요하다면 썬글라스가 준비되어 있습니다. 대부분의 보험은 동공확장을 지원합니다. 보험이 없을시, **20** 불을 부과합니다. 동공확장후 운전이 불편할면, 나중에 다른 운전자와 함께 올 수 있습니다. 아래 옵션 중 하나를 표시 하시오.

_____ **YES, I wish to be dilated today** (금일 동공확장 검사를 원합니다).

_____ **NO, I do not wish to be dilated. I understand that I am assuming all risks associated with refusing this procedure and agree to hold Jane Kim, O.D. harmless as a result of my actions**
(나는 동공확장을 원하지 않습니다. 이로 인한 위험을 인지하며 탁터 김제인에게 피해 주지 않을것을 확인합니다)

Signature (서명): _____ **Date (날짜):** _____/_____/_____

Name and Relationship to Patient (if other than patient)(이름 및 환자와의 관계 – 본인이 아닐 경우): _____

EYEWEAR (FRAMES, LENSES, SUNGLASSES) AGREEGMENT (안경약관):

Please skip if you do **NOT** plan on purchasing with Itali Eye Care (이태리안경에서 안경 구매를 안할경우 넘어가세요)

Our eyeglass lenses are customized for the frame selected, as well as the individual's prescription. As such, half to full payment will be required to start the order, and any changes to eyeglass orders or returns must occur within 30 days of order. All orders are final when placed. No refunds are given on custom made prescription items. *If you are unhappy with your glasses for any reason, please bring them back to us so we may change them to meet your expectations*. This office will recheck any prescription at no cost within 60 days of the date on which the prescription was determined. If you were told at the time of the exam that your glasses will need to be altered for various medical reasons within the 60 day period, this recheck policy does NOT apply, and you may be charged a fee. You must be able to furnish the glasses that you had filled with a valid prescription if not filled through our office. After 60 days, a fee will be incurred for any recheck. Rechecks will not be performed after 6 months from original exam date, and a new eye exam will be necessary. If your eye exam was provided at Itali Eye Care, any remake of lenses as a result of doctor-ordered prescription changes will be done at no charge as a courtesy. If you provide a prescription from another office, any remake of lenses will be done at no charge *only one time* if lenses are of equal or lesser value and will not be subject to a refund of any differences in prices; Any remakes required beyond the one-time service will result in fees for the lenses and any treatments charged at 50% of our usual and customary fees. Frames and lenses purchased from our office have a 6-month *manufacturer defect full-warranty*, *and it does NOT cover acts of abuse, loss, or theft*. If you used insurance to purchase your glasses, your warranty changes from our standard office warranty to your insurance company's warranty. By signing, you acknowledge that you understand the policies regarding the purchase of frames, lenses, and/or sunglasses at Itali Eye Care.

상기 안경약관에 동의 합니다.

Signature (서명): _____ **Date (날짜):** _____/_____/_____

Name and Relationship to Patient (if other than patient)(이름 및 환자와의 관계 – 본인이 아닐 경우): _____

CONTACT LENS AGREEMENT (콘텍렌즈약관):

Please skip if you do **NOT** wear contact lenses (콘텍렌즈를 사용 안하면 다음으로 넘어가세요).

Contact lenses are a medical device that have the potential for serious complications if not used and fitted properly. For this reason, the Texas Board of Optometry requires an annual evaluation for a contact lens prescription (not part of the standard eye health exam), even if you have worn contact lenses in the past. The doctor will assess the health of the cornea (for ulcers, abnormal blood vessel growth, inflammation, etc.), the powers needed based on the patient's visual problems or changes, the stability of the lens on the eye, and the compatibility of the lens material and the eye. The estimated fee for these services range between **$40.00 to $80.00**. These fees will cover any contact lens related follow ups for a *60 day* period. The 60 day period does NOT include visits for medically related eye conditions that may or may not be related to contact lens wear (i.e. eye infections, ulcers, allergies, etc.). If you cannot complete the fitting procedure in the allotted time, then there will be an additional $30.00 charge per visit beyond the global time period. If you are wearing contact lenses for the first time, then there will be an additional $30.00 charge for training how to insert, remove, and take care of the contact lenses. All contact lens fitting fees must be paid in full at the time of examination, and it does NOT include any contact lens supplies/boxes. Half or full payment of contact lens supplies/boxes/vials must be made prior to ordering. Contact lens supplies/boxes may be exchanged or refunded within 30 days of purchase *only* if the product is unopened; otherwise, all contact lens supplies/boxes are non-refundable. By signing, you acknowledge that you understand the policies regarding the fitting of contact lenses and agree to the associated fees. You understand that these fees are an estimate and are subject to changes based on the doctors final assessment. You also understand that improper usage of contact lenses as prescribed can lead to vision loss and permanent eye damage, and if an infection is present you will need to be treated under your medical insurance prior to being fit with contact lenses.

상기 콘텍렌즈 약관에 동의 합니다

Signature (서명): _____ **Date (날짜):** _____/_____/_____

Name and Relationship to Patient (if other than patient) (이름 및 환자와의 관계 – 본인이 아닐 경우): _____