Jennifer P. Wang, M.D. and Associates

General Health and Medical Questionnaire

Date: ______________________________ Name: ____

Age: _____ DOB: _____/_____/_____ Sex: M or F Primary Care Physician: _________________________

Occupation: _________________________ (New Patients) Date Of Last Eye Exam: ______________________

PATIENT HISTORY ** Use back if necessary

List any medications: include all prescriptions and non-prescriptions (ex: aspirin)? ________________________________

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Are you allergic to any medications? Yes or No (If yes, specify)____

List all **major illnesses or injuries** (glaucoma, diabetes, high blood pressure, heart attack, concussion, etc.) ________________

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List any **surgeries** you have had: (cataract, appendectomy) ____

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Have you ever had a **blood transfusion**? **Yes No** Do you wear **glasses? Yes No** **Contacts? Yes No**

Do you have problems in the following areas?	No	Yes	Details
Females: pregnant, nursing.			
General Constitution: fever, weight loss or gain, tired, etc.			
Ears, Nose, Throat: stuffy nose, ear ache, cough, dry mouth, hard of hearing, etc.			
Cardiovascular: high blood pressure, racing pulse, etc.			
Respiratory: congestion, wheezing short of breath, etc.			
Gastrointestinal: stomach upset, diarrhea, constipation, hernia, ulcers, etc.			
Genital, Kidney, Bladder: painful, frequent urination, impotence, jaundice, etc.			
Muscles, Bones, Joints: pain, stiffness, swelling, cramps, arthritis, etc.			
Skin: acne, warts, growths, rash, etc.			
Neurological: numbness, headache, seizures, paralysis, etc.			
Psychiatric: anxiety, depression, insomnia, etc.			
Endocrine: diabetes, hypothyroid, etc.			
Blood, Lymph: bleeding, high cholesterol, anemia related to transfusion, etc.			
Allergic, Immunologic: sneezing, swelling, redness, itching, hives, lupus, etc.			

FAMILY HISTORY

Has any member of your family had any of these diseases? (circle all that apply) Yes No Unknown
Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Other inheritable disease:

SOCIAL HISTORY

Does your vision with correction limit any daily living (driving, reading, sports, work, hobbies, etc.)? **Yes No**
Do you drink alcohol? No Yes occasional 1 day 2-3 day 4+ day
Do you smoke? No Yes occasional ½ pack day 1 pack day 1+ pack day

Jennifer Wang M.D. & Associates
Patient Registration

Patient's Title	□ Mr. □ Mrs. □ Miss	Evening phone	
First Name		Work phone	
Middle Initial		Cell Phone	
Last Name		Social Security #	
Nickname		Employer	
Birth Date & Sex		Occupation	
Street Address		Family/Primary Dr	
City		State	Zip
Who may we thank for referring you?			
E-mail address (We won't give this out! Our communications only) :			

How did you hear about us?
□ Dr. □ Employer □ Friend □ Family □ Insurance □ Mailing □ Paper □ Phone book □ Radio □ Magazine □ Website

Medical Insurance Information

Primary Medical Ins.		**Secondary Medical Ins.**	
ID Number		ID Number	
Group Number		Group Number	
Subscriber name		Subscriber name	
Subscriber birth date		Subscriber birth date	

Vision Insurance Information

Primary Vision Ins.		**Secondary Vision Ins.**	
ID Number		ID Number	
Subscriber name		Subscriber name	
Subscriber birth date		Subscriber birth date	

Minor Patient: I give consent and authorize Dr. Jennifer Wang's office to examine and provide treatment deemed advisable for this minor.

Guardian's Signature _________________________ Date ___________ Relationship ________________

Insurance Authorization and Financial Agreement: I hereby authorize Dr. Jennifer Wang's office to release my diagnosis to determine the benefits payable for related services to any insurance carrier I have. I hereby authorize payment directly to Dr. Jennifer Wang's office. I understand that I am responsible for any amount not covered by insurance including deductible, coinsurance, and non-covered services. This assignment will remain in effect until revoked by me in writing. I agree it is the patient's responsibility to know which providers are in their network and which services are covered by their plan.

Privacy Notice: I have received the Notice of Privacy Practices attached. I hereby authorize the physicians and staff of Dr. Jennifer Wang's office to convey information about my health to the following people:

Name____ Relationship _________________

I HAVE RECEIVED THE "NOTICE OF PRIVACY". I AGREE TO THE ABOVE FINANCIAL STATEMENTS.

Patient's Signature ____ Date ___________________

Jennifer P. Wang, M.D. & Associates

525 South Drive Suite 219-Mountain View, CA 94040
(650) 969-4600
3520 Alameda De Las Pulgas-Menlo Park, CA 94025
(650) 321-4500

Jennifer P. Wang, M.D. & Associates is committed to providing you with the best possible medical care. If you are covered by medical insurance, we wish to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our financial policy. We are contracted with many insurance companies and if you have a question regarding whether or not we are contracted with your plan, please contact your insurance company as they can best answer your questions.

In order to be able to file your insurance claims, we must have a copy of your insurance card. When there is a change in your insurance plan or coverage, please notify us as soon as possible.

Without this information, we will be unable to submit your claim to your insurance for payment.

1. Your insurance coverage is a contract between you and /or your employer, and the insurance company. We are not a party to that contract.

2. As a specialist, some insurance companies require that prior to any visit; you must obtain an authorization or referral from your primary care physician (PCP). If this is not done by the time of your appointment, you will be asked to either reschedule your appointment and contact your PCP, or pay for the services at the time you are seen. Any payments made at the time of service will be promptly refunded upon receipt of payment by the insurance company. Please note that most insurance companies will only cover the cost of the services listed on the authorization or referral. Any services which are not authorized or denied by your insurance company are your responsibility.

3. **Co-payments, if required by your plan, are due at the time of each visit.** Please come prepared to pay the copayment as determined by your insurance plan (most copayments are listed on your insurance card). Most insurance companies require that this amount be paid at the time of service in order to validate the contract.

4. No matter what type of plan you have, HMO, PPO, POS or Indemnity, **it is to your advantage, as well as your responsibility, to know and understand your medical insurance coverage. Not all services are a covered benefit in all contracts.** Contact your insurance company to find out what benefits are covered under your plan.

5. We request that as a courtesy to our other patients, that you **please notify us at least 24 hours in advance if you will be unable to keep your appointment**. We reserve the right to charge for any appointment which is not cancelled with proper notice. We must emphasize that as medical care providers, our relationship is with you, not with your insurance company. Therefore, all costs for services provided remain the responsibility of the patient/guarantor from the date the service is rendered. We realize that temporary financial problems may affect timely payment in your account. If such problems do arise, we encourage you to contact us promptly for assistance in management of your account.

I HAVE READ THE ABOVE FINANCIAL ARRANGEMENTS AND INSURANCE STATEMENT AND I REALIZE THAT PAYMENT IS MY OBLIGATION FOR COVERED AND NON-COVERED SERVICES REGARDLESS OF INSURANCE OR THIRD PARTY INVOLVEMENT. I AUTHORIZE THE PHYSICIAN TO FURNISH MY INSURANCE COMPANY WITH ANY INFORMATION REQUIRED AND MY INSURANCE BENEFIT PAYMENTS TO GO TO JENNIFER P. WANG, M.D. & ASSOCIATES.

____

PATIENT SIGNATURE (guarantor, if patient is a minor)   Date

Jennifer P. Wang, M.D.

3520 Alameda de las Pulgas Menlo Park, CA 94025 525 South Drive #219 Mountain View, CA 94040

1.) What brings you in for your visit today?

Routine Eye Exam

Specific problem___________________________________

2.)Are you interested in Glasses, Contact Lenses, or LASIK ?

3.)What issues would you like to discuss with the Doctor at today's visit?

4.)Do you have any of the following conditions:

High Blood Pressure

Diabetes

High Cholesterol

5.)Are you interested in any Cosmetic Products or Procedures

Botox/Dysport

Latisse Lash Enhancer

Restylane/Perlane

Colorscience Makeup

Obagi/ Chemical Peels

Kybella

6.) Email Address: ____

(We do not give this out. Our office communications only.)

OFFICES OF JENNIFER P. WANG, M.D.
SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length notice is available upon request.

Date of Last Revision: March 20, 2003
Effective Date: Immediately

This information is made available on request by a patient

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail, please refer to the Notice of Privacy Practices that follows this summary):

Uses and Disclosures:

Treatment: Your health information may be used by our physicians and staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. This may be necessary in our communications with your pharmacy, with optical vendors to manufacture your glasses or contact lenses.

Payment: We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose Protected Health Information to a health plan in order for the health plan to pay us for the services rendered to you. We may also tell your health plan about a treatment or procedure you are going to receive in order to obtain prior approval or to determine whether your plan will cover the services.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of Jennifer P. Wang, M.D. and Associates. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality to insure that our practice is meeting state and federal guidelines and laws designated to protect your health care information. Your health information will be used by our staff to call or send you appointment reminders or billing issues. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information on related goods and services that we believe may interest you.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, our practice is required to report certain communicable diseases to the State of California Department of Health.

Other Uses and Disclosures: Your health information may be disclosed for research, for organ and tissue donation, or in response to certain requests arising out of lawsuits or other disputes.

Some Uses And Disclosures Require Your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before your notified us of your decision.

Information About Treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights: You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to request an amendment or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Jennifer P. Wang, M.D. and Associates Duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information: As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Medical Records Clerk.

Complaints and Contact Person: If you would like to submit a comment or complaint about our privacy practices, or obtain additional information about our privacy practices, you can do so by sending a letter outlining your concerns to the person listed below. You will not be penalized or otherwise retaliated against for filing a complaint.

Practice Manager
Jennifer P. Wang M.D. and Associates

525 South Drive, Suite 219
Mountain View, CA 94040
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For more information about these rights please see the detailed Notice of Privacy Practices that follows this summary.