

WELCOME TO



PATIENT INFORMATION

Date _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____

If patient is a minor, name of Guardian _____

Home Phone _____

Cell Phone _____

Best time and place to reach you _____

Whom may we thank for referring you? _____

Is this a routine eye examination? Yes No

If not; What is your primary eye complaint? _____

E-mail address _____

Pharmacy _____

EMPLOYER INFORMATION

Occupation _____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

Employer Phone _____

IN CASE OF EMERGENCY, CONTACT:

Name _____

Relationship _____

Home Phone _____

Cell Phone _____

HEALTH HISTORY

Primary Care Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following conditions. Also, place a mark to indicate if a blood relative has had any of the following problems.

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis (Type _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lazy Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor Color Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Turned Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant? _____		
Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco use _____	Alcohol use _____	

EYE HEALTH HISTORY

Eye Physician's Name: _____

Date of last eye exam: _____

Do you wear glasses? Yes No

All the time Occasionally

Reading Driving TV

Do you wear contacts? Yes No

Brand _____ Hours/Day _____

Describe any problems you have with

your contacts _____

Place a mark on "Yes" or "No" to indicate if you have any of the following:

- | | | | |
|----------------------------|--|--------------------------|--|
| Blood Shot Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Floaters or Spots | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blurred Vision - Distance | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blurred Vision - Near | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Burning Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Itching Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Light Sensitive | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Color Vision, Poor | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loss of Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Crossed Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Discharge from Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Night Vision, Poor | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dizzy Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | Red Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Double Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seeing Halos | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dry Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seeing Flashes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Infection | <input type="checkbox"/> Yes <input type="checkbox"/> No | Temporary Loss of Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Injury | <input type="checkbox"/> Yes <input type="checkbox"/> No | Twitching Eyelid | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Strain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vision Poor | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting Spells, Blackouts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Watering Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No |

MEDICATIONS

List of medications you are currently taking, including eye drops:

Please see attached medication list

Allergies _____

MEDICAL AUTHORIZATION

MEDICARE AND INSURANCE AUTHORIZATION

I authorize direct payment of Medicare and / or Insurance benefits on my behalf to New Jersey Regional Eye Care. I further authorize release of all relevant medical information needed to determine these benefits. As a participating provider, New Jersey Regional Eye Care, agrees to accept, in full, payment by my insurance plan for covered services rendered. I agree to pay for all co-payments, deductibles and non-covered services at the time of my office visit. I understand that health insurance plans are continuously changing in regard to their benefits and requirements, and it is my responsibility as a patient to be aware of and inform New Jersey Regional Eye Care as to the details of my individual plan prior to my office visit. I am aware that under no circumstance will referrals, pre-certifications, or insurance plan information be accepted after my office visit. I am also aware that if all relevant insurance information is not provided by me prior to my office visit, resulting in denial of or delayed payment of a claim for more than 90 days, I will be fully responsible for payment in full for all services provided.

NOTICE OF PRIVACY PRACTICES

I have been offered / received a copy of New Jersey Regional Eye Care's notice of privacy practices.

Signature

Date



New Jersey Regional Eye Care

Thank You