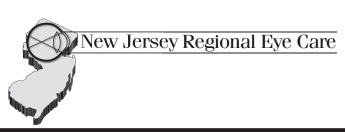
## WELCOME TO



PATIE	ENT INFORMAT	ION	EMPLOYER INFORMATION				
		Date					
Patient			Occupation				
Address							
			Employer				
City State Zip			Employer Address				
Sex: □M □F Age_	Birthdate						
Height, Weight			City	Sta	te Zip		
If patient is a minor, name of Guardian							
ii patient is a inmor, nan	ne or Guardian		Employer Phone				
Home Phone			IN CASE OF EMERGENCY, CONTACT:				
Cell Phone			Name				
Best time and place to re	each you		Name				
Whom may we thank for	r referring you?	<del></del>	Relationship				
Is this a routine eye examination? □Yes □No			Home Phone				
If not; What is your primary eye complaint?							
E-mail address			Cell Phone				
Pharmacy							
		HEALTH	I IIICTODV				
		ПБУПП	HISTORY				
Primary Care Physician's Name							
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	□Yes □No	□Yes □No	High Blood Pressure	□Yes □No	□Yes □No		
Arthritis	□Yes □No	□Yes □No	Kidney Disease	□Yes □No	□Yes □No		
Artificial Heart Valve	□Yes □No	□Yes □No	Lupus	□Yes □No	□Yes □No		
Artificial Joints	□Yes □No	□Yes □No	Migraine Headaches	□Yes □No	□Yes □No		
Asthma	□Yes □No	□Yes □No	Multiple Sclerosis	□Yes □No	□Yes □No		
Bleeding	□Yes □No	□Yes □No	Pacemaker	□Yes □No	□Yes □No		
Blindness	□Yes □No	□Yes □No	Rheumatic Fever	□Yes □No	□Yes □No		
Cancer	□Yes □No	□Yes □No	Shingles	□Yes □No	□Yes □No		
Chemical Dependency	□Yes □No	□Yes □No	Skin Condition	□Yes □No	□Yes □No		
Diabetes	□Yes □No	□Yes □No	Stroke	□Yes □No	□Yes □No		
Drug Sensitivity	□Yes □No	□Yes □No	Thyroid Conditions	□Yes □No	□Yes □No		
Emphysema	□Yes □No	□Yes □No	Tuberculosis	□Yes □No	□Yes □No		
Epilepsy	□Yes □No	□Yes □No					
Eye Surgery	□Yes □No	□Yes □No					
Hay Fever	□Yes □No	□Yes □No					
Heart Condition	□Yes □No	□Yes □No					
Hepatitis (Type)	□Yes □No	□Yes □No					
, , , , , , , , , , , , , , , , , , , ,			Are you pregnant?				
			Tobacco use				
□Yes □No	□Yes □No			inconor di			

	EYE HEALTH HIST	UKI		
	Place a mark on "Yes" or "	"No" to indicate if y	ou have any of the following	;:
Eye Physician's Name:	Blood Shot Eyes	□Yes □No	Floaters or Spots	☐Yes □No
Lye i nysician s ivame.	Blurred Vision - Distance	□Yes □No	Glaucoma	□Yes □No
	Blurred Vision - Near	□Yes □No	Headaches	□Yes □No
Date of last eye exam	— Burning Eyes	□Yes □No	Itching Eyes	□Yes □No
Do you wear glasses? □Yes □No	Cataracts	□Yes □No	Light Sensitive	□Yes □No
☐ All the time ☐ Occasionally	Color Vision, Poor	□Yes □No	Loss of Vision	□Yes □No
□Reading □Driving □TV	Crossed Eyes/Lazy Eye	□Yes □No	Migraine Headaches	□Yes □No
Do you wear contacts? □Yes □No	Discharge from Eyes	□Yes □No	Night Vision, Poor	□Yes □No
•	Dizzy Spells	□Yes □No	Red Eyes Retinal Disease	□Yes □No
Type Hours/Day		□Yes □No	Seeing Halos	□Yes □No □Yes □No
Describe any problems you have with	Dry Eyes  Eye Infection	□Yes □No □Yes □No	Seeing Flashes	□Yes □No
your contacts	Eye Injury	□Yes □No	Temporary Loss of Visi	
	Eye Strain	□Yes □No	Twitching Eyelid	□Yes □No
	Eye Surgery	□Yes □No	Vision Poor	□Yes □No
	Fainting Spells, Blackouts	□Yes □No	Watering Eyes	□Yes □No
	Tunking Spens, Blackouts	21 <b>0</b> 5 2110	8 3	
ALLERGIES				
List your allergies to medications or other substar	nces:			
	MEDICAL AUTHORI	ZATION		
MEDICARE AND INSURANCE AUTHORIZ	ATION			
I authorize direct payment of Medicare and release of all relevant medical information of Care, agrees to accept, in full, payment by mibles and non-covered services at the time of regard to their benefits and requirements, and Care as to the details of my individual plan fications, or insurance plan information be a not provided by me prior to my office visit, responsible for payment in full for all services.	needed to determine these bene by insurance plan for covered second my office visit. I understand that it is my responsibility as a proprior to my office visit. I am accepted after my office visit. I resulting in denial of or delayer	fits. As a participativices rendered. In that health insuration to be aware aware that under am also aware the	ating provider, New Jerser agree to pay for all co-pay rance plans are continuous of and inform New Jerser no circumstance will refeat if all relevant insurance	y Regional Eye yments, deduct- sly changing in y Regional Eye errals, pre-certi- e information is
NOTICE OF PRIVACY PRACTICES  I have received a copy of New Jersey Regional E		es. Ne	w Jersey Regiona	ll Eye Care
			Thank You	$\iota$
Signature	Date			