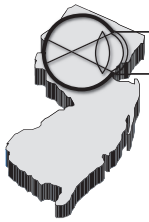
WELCOME TO



New Jersey Regional Eye Care

PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____
City State Zip

Sex: ☐M ☐F Age_____ Birthdate_____

Patient SS#_____

Home Phone_____

Work Phone_____Ext_____

Spouse's Work 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_____

INSURANCE

Name of Policy Holder_____

Relationship to Patient_____

Birthdate_____SS#_____

Insurance Co. _____

Group #_____

Do you need a referral from your primary physician? ☐Yes ☐No

Primary Physician's Name_____

Is the patient covered by additional insurance? ☐Yes ☐No

Secondary Subscriber Name_____

Birthdate_____SS#_____

Relationship to Patient_____

Insurance Co._____

Do you have a separate vision plan? ☐Yes ☐No

If yes; name of plan:_____

EMPLOYER INFORMATION

Occupation_____ Employer_____

Employer Address_____Employer Phone_____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name_____ Relationship_____

Home Phone_____Work Phone_____

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

Type_____ 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	☐Yes	☐No	Floaters or Spots	☐Yes	☐No
Blurred Vision - Distance	☐Yes	☐No	Glaucoma	☐Yes	☐No
Blurred Vision - Near	☐Yes	☐No	Headaches	☐Yes	☐No
Burning Eyes	☐Yes	☐No	Itching Eyes	☐Yes	☐No
Cataracts	☐Yes	☐No	Light Sensitive	☐Yes	☐No
Color Vision, Poor	☐Yes	☐No	Loss of Vision	☐Yes	☐No
Crossed Eyes	☐Yes	☐No	Migraine Headaches	☐Yes	☐No
Discharge from Eyes	☐Yes	☐No	Night Vision, Poor	☐Yes	☐No
Dizzy Spells	☐Yes	☐No	Red Eyes	☐Yes	☐No
Double Vision	☐Yes	☐No	Seeing Halos	☐Yes	☐No
Dry Eyes	☐Yes	☐No	Seeing Flashes	☐Yes	☐No
Eye Infection	☐Yes	☐No	Temporary Loss of Vision	☐Yes	☐No
Eye Injury	☐Yes	☐No	Twitching Eyelid	☐Yes	☐No
Eye Strain	☐Yes	☐No	Vision Poor	☐Yes	☐No
Fainting Spells, Blackouts	☐Yes	☐No	Watering Eyes	☐Yes	☐No

- OVER -

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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	☐Yes ☐No	☐Yes ☐No	Hepatitis (Type_____)	☐Yes ☐No	☐Yes ☐No
Arthritis	☐Yes ☐No	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	☐Yes ☐No	Kidney Disease	☐Yes ☐No	☐Yes ☐No
Artificial Joints	☐Yes ☐No	☐Yes ☐No	Lazy Eye	☐Yes ☐No	☐Yes ☐No
Asthma	☐Yes ☐No	☐Yes ☐No	Lupus	☐Yes ☐No	☐Yes ☐No
Bleeding	☐Yes ☐No	☐Yes ☐No	Migraine Headaches	☐Yes ☐No	☐Yes ☐No
Blindness	☐Yes ☐No	☐Yes ☐No	Pacemaker	☐Yes ☐No	☐Yes ☐No
Cancer	☐Yes ☐No	☐Yes ☐No	Poor Color Vision	☐Yes ☐No	☐Yes ☐No
Cataracts	☐Yes ☐No	☐Yes ☐No	Retinal Disease	☐Yes ☐No	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No	☐Yes ☐No
Diabetes	☐Yes ☐No	☐Yes ☐No	Shingles	☐Yes ☐No	☐Yes ☐No
Drug Sensitivity	☐Yes ☐No	☐Yes ☐No	Skin Condition	☐Yes ☐No	☐Yes ☐No
Emphysema	☐Yes ☐No	☐Yes ☐No	Stroke	☐Yes ☐No	☐Yes ☐No
Epilepsy	☐Yes ☐No	☐Yes ☐No	Thyroid Conditions	☐Yes ☐No	☐Yes ☐No
Eye Surgery	☐Yes ☐No	☐Yes ☐No	Tuberculosis	☐Yes ☐No	☐Yes ☐No
Glaucoma	☐Yes ☐No	☐Yes ☐No	Turned Eye	☐Yes ☐No	☐Yes ☐No
Hay Fever	☐Yes ☐No	☐Yes ☐No			
Heart Condition	☐Yes ☐No	☐Yes ☐No			

Are you pregnant? _____Number of Children_____

Tobacco use_____Alcohol use_____

MEDICATIONS

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

_____

_____

_____

_____

ALLERGIES

List your allergies to medications or other substances:

_____

_____

_____

_____

MEDICAL AUTHORIZATION

MEDICARE AND INSURANCE AUTHORIZATION

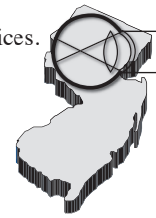
I authorize direct payment of Medicare and / or Insurance benefits on my behalf to New Jersey Regional Eye Care. I further authorize release of all relevant medical information needed to determine these benefits. As a participating provider, New Jersey Regional Eye Care, agrees to accept, in full, payment 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 received a copy of New Jersey Regional Eye Care's notice of privacy practices.

_____ _____

Signature of Beneficiary Date



New Jersey Regional Eye Care

Thank You