# WELCOME TO

New Jersey Regional Eye Care

## PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____
City State Zip

Sex: ☐M ☐F Age_____ Birthdate_____

Height_____, Weight_____

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 | ☐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 | | | |
| | ☐Yes ☐No | ☐Yes ☐No | | | |

Are you pregnant? _____

Tobacco use_____Alcohol use_____

- OVER -

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## 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/Lazy Eye | ☐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 | Retinal Disease | ☐Yes | ☐No |
| Dry Eyes | ☐Yes | ☐No | Seeing Halos | ☐Yes | ☐No |
| Eye Infection | ☐Yes | ☐No | Seeing Flashes | ☐Yes | ☐No |
| Eye Injury | ☐Yes | ☐No | Temporary Loss of Vision | ☐Yes | ☐No |
| 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 |

## 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 Date

New Jersey Regional Eye Care

*Thank You*