ASSOCIATES In OPHTHALMOLOGY LLC

Please Complete All The Questions on This Form

Today's Date: _____

Patient's Name: _____ **Date of Birth:** _____
Address: _____ **Phone:** _____
City/State: _____ **Zip Code:** _____
Social Security #: _____ **Occupation:** _____
Employer: _____ **Address:** _____
Business Phone: _____
E-Mail address: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

How did you hear about us?
☐ A friend
Name of friend: _____
☐ Referred by doctor
Name of doctor: _____
☐ Online ☐ Insurance Company

Insurance Subscriber Information:
☐ Same as patient above
☐ Different than patient above:
Name: _____ Date of Birth: _____
Address: _____
_____ Phone: _____
_____ Relationship: _____

Guarantor Information (person responsible for bill):
☐ Same as patient above
☐ Different than patient above:
Name: _____ Date of Birth: _____
Address: _____
_____ Phone: _____
_____ Relationship: _____

Name of Emergency Contact: _____
Phone: _____ **Relationship:** _____

Insurance Authorization and Assignment:
I hereby authorize Associates in Ophthalmology, LLC to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to Associates in Ophthalmology all payments for medical services rendered to myself and/or my dependents. I understand I am responsible for any amount not covered by insurance. I understand it is my responsibility to obtain necessary referral forms when appropriate and, lacking these, I must personally pay for doctor's services before leaving the office unless other arrangements are made and approved.
Signature: _____ Date: _____

PATIENT NAME: _____

Medical History Questionnaire

Date of last eye exam: _____

Please check box(es) if have had any of the following:

Past Medical History: □ None

□ Anxiety/Depression □ Arthritis □ Asthma □ Cancer □ Diabetes
□ High Blood Pressure □ Hypercholesterolemia □ Thyroid Abnormality
□ Seizure □ Stroke □ Other: _____

Ocular History: □ None

□ Blepharitis □ Cataracts □ Contacts □ Glasses
□ Dry Eyes □ Glaucoma □ Floaters □ Macular Degeneration
□ Retinal Hole/detachment □ Other: _____

Review of Systems: Please check box(es) if you **currently** have any problems in the following areas:

□ Have no current medical problems.

Head

□ Headaches
□ Migraines

Eyes

□ Loss of vision
□ Blurred vision
□ Distorted vision (halos)
□ Loss of side vision
□ Double vision
□ Dryness
□ Discharge
□ Redness
□ Sandy or gritty feeling
□ Itching
□ Burning
□ Foreign body sensation
□ Tearing/watering
□ Glare/light sensitivity
□ Eye pain
□ Tired Eyes

□ Bones, Joints, Muscles
□ Cardiovascular
□ Respiratory
□ Gastrointestinal
□ Genitourinary
□ Lymphatics/Hematopopoletic
□ Neurological System
□ Allergic/Immunologic
□ Psychiatric
□ Endocrine
□ Diabetes
Last Hemoglobin A1C: _____
Last fasting blood sugar level: _____
□ Integument (skin)
□ Ear, Nose, Mouth, and Throat

Any major illnesses or injuries:

_____
_____
_____

Medications (Include dosage. Copies can be made of lists): □ None

_____
_____
_____
_____

PRIMARY PHYSICIAN INFORMATION

NAME: _____ **PHONE:** _____
ADDRESS: _____

PATIENT NAME:_____

Surgical History (Please include any eye surgeries): □ None

_____

_____

_____

Allergies to Medications: □ Yes □ No

If yes, list allergies: _____

Family History:

□ Adopted and have no record of family history

	Relation to patient:
□ Blindness	_____
□ Glaucoma	_____
□ Macular Degeneration	_____
□ Retinal Detachment	_____
□ Arthritis	_____
□ Cancer	_____
□ Diabetes	_____
□ Gout	_____
□ Heart Attacks	_____
□ High Blood Pressure	_____
□ Kidney Disease	_____
□ Lupus	_____
□ Sjogrens Syndrome	_____
□ Stroke	_____
□ Thyroid Disease	_____
□ Tuberculosis	_____
□ Other:	_____

Social History:

Do you currently drive? □ Yes □ No

Do you have difficulty seeing when driving? □ Yes □ No

Do you have problems driving at night? □ Yes □ No

Do you currently wear glasses? □Yes □ No contact lenses? □ Yes □ No

How long have you worn contact lenses for? _____

What contacts do you wear? _____

Are you interested in learning if you are a candidate for LASIK Surgery? □ Yes □ No

Are you interested in learning about Latisse? □ Yes □ No

Do you use any street drugs? □ Yes,_____ □ No

Do you drink alcohol? □ Yes, _____times a week □ No

Do you smoke cigarettes/cigars? □ Yes, _____ times a week □ No

To **ACCESS Patient Portal** please add email address :

_____

Andrew Miller, MD Bardha Fejzo, OD
22 Old Short Hills Road Ste. 102
Livingston, NJ 07039
PH: (973) 992-5200 Fax: (973) 535-5741
www.associatesinophthalmology.com

Privacy Agreement

With regards to HIPAA compliance, our doctors/staff are unable to give any medical or personal information (diagnosis/treatment information, appointment times, prescriptions, etc) to a family member/friend without written authorization from the patient. If you would like to allow us to speak with a family member/friend, please provide their name and your signature below.

Person with whom we can share information _____ Relation _____

Phone(Optional) _____

VII. Effective Date of this notice is April 14, 2003

I acknowledge receipt of Associates in Ophthalmology, LLC's patient privacy rights.

Patient Name (Print) _____ Patient Name (Signature) _____ Date _____

Meaningful Use

Race
__ American Indian or Alaska Native
__ Asian
__ Black or African American
__ Native Hawaiian or Other Pacific Islander
__ White
__ Other
__ Decline to Specify

Ethnicity
__Hispanic or Latino
__Not Hispanic or Latino
__ Decline to Specify

Preferred Language
__ English
__Spanish
__Other/Specify:_____

ASSOCIATES in OPHTHALMOLOGY LLC

Andrew Miller, MD
Bardha Fejzo, OD
22 Old Short Hills Road Ste. 102 Livingston, NJ 07039
PH: (973) 992-5200 Fax: (973) 535-5741
www.associatesinophthalmology.com

Pharmacy Information

Patient Name: _____ **Date of Birth:** _____

Pharmacy Name: _____ **Pharmacy Number:** _____

Pharmacy Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____