Please Complete All The Questions on This Form

Today's Date: _____

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

Employer: _____ **Phone:** _____
Address: _____

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 other major illnesses or injuries:
_____
_____
_____

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

_____
_____
_____

Allergies to Medications: □ Yes □ No

If yes, list allergies: _____

Patient Name: _____

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

_____

_____

_____

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

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

Patient Name: _____ DOB: _____

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

_____

Primary Care Physician Information:

Doctor Name: _____ **Practice Number:** _____

Practice Street Address: _____

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

Preferred Pharmacy Information:

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

Pharmacy Street Address: _____

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

ASSOCIATES in OPHTHALMOLOGY LLC

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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:_____

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Refraction Form

Refraction- Is the determination of the eyeglasses prescription (even if you don't need or wear glasses). This vision related service is not covered by many insurance plans, including Medicare and HMO's, even though it is recognized as an integral part of a comprehensive eye exam.

Depending on your insurance coverage, we will collect the **$50 payment** for refraction on the date of your visit. Otherwise, we will bill your insurance company for the refraction. If your insurance company declines payment, you will be responsible for the bill.

□ I **would like** refraction done today.

□ I **decline** refraction today.

_____ X_____
Print Patient Name Signature: Patient or Legal Guardian

_____ _____
Print Parent/Guardian Name (If Patient is a Minor) Date