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: ____

Preferred method of communication: □ Phone □ Text □ Email

How did you hear about us?
□ A friend: ___________________________________
□ Referred by doctor: ___________________________
□ Online □ Insurance Company

Insurance Subscriber Information:
□ Same as patient above
□ Different than patient above:
Name: __________________________ Date of Birth: ______________
Address: ________________________ Relationship: ______________
________________________ Phone: ___________________

Guarantor Information (person responsible for bill):
□ Same as patient above
□ Different than patient above:
Name: __________________________ Date of Birth: ______________
Address: ________________________ Relationship: ______________
________________________ Phone: ___________________

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 ◻ Diabetes
◻ High Blood Pressure ◻ High Cholesterol ◻ Hyper/Hypothyroidism
◻ Seizure ◻ Stroke ◻ Cancer: ___________ ◻ 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 surgeries): ☐ None

____
____
____

Family History:

☐ Adopted and have no record of family history

Relation to patient:

	Mother	Father	
☐ Blindness	☐	☐	Other: ____________
☐ Glaucoma	☐	☐	Other: ____________
☐ Macular Degeneration	☐	☐	Other: ____________
☐ Retinal Detachment	☐	☐	Other: ____________
☐ Arthritis	☐	☐	Other: ____________
☐ Cancer	☐	☐	Other: ____________
☐ Diabetes	☐	☐	Other: ____________
☐ Gout	☐	☐	Other: ____________
☐ Heart Attacks	☐	☐	Other: ____________
☐ High Blood Pressure	☐	☐	Other: ____________
☐ Kidney Disease	☐	☐	Other: ____________
☐ Lupus	☐	☐	Other: ____________
☐ Sjogrens Syndrome	☐	☐	Other: ____________
☐ Stroke	☐	☐	Other: ____________
☐ Thyroid Disease	☐	☐	Other: ____________
☐ Tuberculosis	☐	☐	Other: ____________
☐ Other: _____________	☐	☐	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? ☐ Current smoker ☐ Former Smoker ☐Never

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

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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*Please **READ** before signing. Thank you.*

Refraction- Is the determination of the eyeglasses prescription (even if you don't currently wear glasses). The doctor **CANNOT** give you a new/updated glasses prescription without doing a refraction. If you would like to know if there has been a change in your prescription, the refraction needs to be done.
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.

We **WILL** bill your insurance company for the refraction. **If your insurance company declines payment, you will be responsible for the $75 bill.**

_____________________________ X_____________________________

Print Patient Name Signature: Patient or Legal Guardian

_____________________________ _____________________________

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

DEQ 5

1. **Questions about EYE DISCOMFORT:**

a. During a typical day in the past month, how often did your eyes feel *discomfort*?

0 Never
1 Rarely
2 Sometimes
3 Frequently
4 Constantly

b. When your eyes felt discomfort, how intense was this feeling of discomfort at the end of the day, within two hours of going to bed?

Never have	Not at all Intense				Very Intense
0	1	2	3	4	5

2. **Questions about EYE DRYNESS:**

a. During a typical day in the past month, how often did your eyes feel *dry*?

0 Never
1 Rarely
2 Sometimes
3 Frequently
4 Constantly

b. When your eyes felt dry, how intense was the feeling of dryness at the end of the day, within two hours of going to bed?

Never have	Not at all Intense				Very Intense
0	1	2	3	4	5

3. **Questions about WATERY EYES:**

a. During a typical day in the past month, how often did your eyes look or feel excessively *watery*?

0 Never
1 Rarely
2 Sometimes
3 Frequently
4 Constantly

Score: 1a + 1b + 2a + 2b + 3a = Total
__ + __ +__ + __ + __ = ____

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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:** _____________