SHORT HILLS OPHTHALMOLOGY GROUP

DATE:_____ **ACCOUNT #**_____

TITLE: MR:____ **MRS:**__ **MS:**___ **DR:**___ **FULL NAME:**_____

DATE OF BIRTH:_____ **SEX: MALE**____ **FEMALE**___ **SS#**_____

ADDRESS:_____ **APT#**_____

CITY:_____ **STATE:**_____ **ZIP CODE:**_____

PHONE #:_____ **CELL #:**_____ **WORK #:**_____

E-MAIL ADDRESS:_____ **MAY WE EMAIL YOU? YES**____ **NO**___

EMERGENCY CONTACT:_____ **RELATION TO PATIENT:**_____

PHONE#:_____ **E-MAIL ADDRESS:**_____

PATIENT'S EMPLOYER:_____ **OCCUPATION:**_____

EMPLOYER ADDRESS:_____

PREFERRED PHARMACY:_____ **ZIP CODE:** _____

PRIMARY INSURANCE **SECONDARY INSURANCE**

INS. COMPANY NAME:_____ _____

FOR PATIENTS UNDER THE AGE OF 18, WE REQUIRE TO HAVE GUARDIAN'S INFORMATION BELOW:

FULL NAME:_____ **RELATIONSHIP TO PT.:**_____

DOB:_____ **SS#**_____ **PHONE #**_____

DRIVER'S LICENSE #_____ **(PLEASE GIVE FRONT DESK YOUR DL TO SCAN)**

ADDRESS (IF DIFFERENT THAN PT):_____

NOTE: WE DO NOT ACCEPT ANY VISION PLAN EXCEPT VISION SERVICE PLAN (VSP)!

DO YOU HAVE VSP? YES_____**NO**____ **ARE YOU USING YOUR VSP BENEFITS TODAY? YES**___ **NO**____

MEDICAL DR NAME:_____ **MEDICAL DR PHONE #:**_____

WHO REFERRED YOU TO OUR OFFICE?_____

Our office performs medical examinations and bills through your medical insurance. If you have a Vision Service Plan (VSP), we must be notified at EVERY visit that you would like to use your VSP benefits, as we need to receive authorization prior to your visit.

A refraction is a diagnostic test used to determine your best corrected vision. This test is performed on your first visit with us, your annual visit, and anytime your vision decreases significantly. A refraction is a vital test to the care of your eyes because it allows for assessment of your current eye health and the detection of eye diseases. We may provide you with a prescription to update your glasses or it may be medically necessary by your insurance to determine if you qualify for certain eye procedures such as, cataract or laser eye surgery. Even though this is a vital test to the care of your eyes, a refraction is a non-covered service through Medicare, and most insurance plans. Unfortunately, they do not differentiate between "medical refractions" and refractions performed solely for the purpose of providing glasses. We are required to charge for this service regardless of whether insurance will pay.

By signing below, you understand and agree that if your insurance does not cover the refraction (CPT Code 92015), you will be responsible for this charge.

SIGNATURE:_____ **DATE:**_____

PATIENT HISTORY RECORD

NAME:_____ **DATE:**_____

WHAT PROBLEMS ARE YOU HAVING WITH YOUR EYES?_____

_____

DATE OF YOUR LAST EYE EXAM:_____ **WHO PERFORMED THE EXAM?**_____
DO YOU WEAR GLASSES?_____ **HAVE YOU WORN GLASSES IN THE PAST?**_____
HOW OLD ARE YOUR GLASSES FOR DISTANCE?_____ **READING?**_____
DO YOU WISH TO HAVE YOUR GLASSES CHANGED?_____

DO YOU WEAR CONTACT LENSES?____ **HARD**__ **SOFT**__ **TYPE, IF KNOWN?**_____
HOW OLD ARE YOUR PRESENT CONTACT LENSES?_____ **USUAL CLEANING METHOD:**_____
DO YOU SLEEP IN YOUR CONTACT LENSES? Y/N HOW OFTEN?_____

HAVE YOU EVER BEEN TREATED FOR AN EYE CONDITION PREVIOUSLY? (INFECTIONS, ACCIDENTS) Y/N
EXPLAIN:_____

HAVE YOU EVER HAD SURGERY ON YOUR EYES, INCLUDING LASER AND LASER VISION CORRECTION? Y/N
EXPLAIN:_____

IS THERE A FAMILY HISTORY OF SERIOUS EYE DISEASE (GLAUCOMA, RETINAL DISEASE, BLINDNESS FOR ANY REASON)? Y/N EXPLAIN:_____

ARE YOU INTERESTED IN FINDING OUT ABOUT LASER VISION CORRECTION? Y/N

LIST ALL CURRENT AND PAST MEDICAL CONDITION FOR WHICH YOU ARE BEING OR HAVE BEEN TREATED FOR:

_____

LIST ALL HOSPITALIZATIONS AND SURGERIES:_____

_____

DESCRIBE ANY FAMILY HISTORY OF MEDICAL CONDITIONS:_____

LIST ALL CURRENT MEDICATIONS: _____

_____

LIST ANY FOOD OR DRUG ALLERGIES:_____

PLEASE CHECK OFF ALL INFORMATION PERTAINING TO YOUR MEDICAL HISTORY AND EXPLAIN IN THE SPACES:

☐CHRONIC FEVER, UNEXPECTED WEIGHT LOSS/GAIN, FATIGUE EXPLAIN:_____
☐EAR/NOSE/THROAT PROBLEMS (HEARING LOSS, SINUS PROBLEM) EXPLAIN:_____
☐HEART PROBLEMS (CHEST PAIN, IRREGULAR HEARTBEAT) EXPLAIN:_____
☐RESPIRATORY PROBLEMS (SHORTNESS OF BREATH, COUGH, ETC) EXPLAIN:_____
☐GASTROINTESTINAL (HEARTBURN, ABDOMINAL PAIN, VOMITING) EXPLAIN:_____
☐URINARY PROBLEMS (PAIN, DISCOMFORT, BLOOD IN URINE) EXPLAIN:_____
☐SKIN PROBLEMS (RASHES, DRYNESS) EXPLAIN:_____
☐MUSCULOSKELETAL PROBLEMS (ACHES, JOIN PAIN, SWELLING) EXPLAIN:_____
☐NEUROLOGIC PROBLEMS (NUMBNESS, HEADACHES, PARALYSIS) EXPLAIN:_____
☐PSYCHIATRIC PROBLEMS (DEPRESSION, ANXIETY) EXPLAIN:_____
☐THYROID EXPLAIN:_____
☐DIABETES ☐TYPE I ☐TYPE II HOW LONG?_____
☐HIV/AIDS
FLU VACCINE? Y/N PNEUMONIA VACCINE? Y/N
DO YOU SMOKE? Y/N QUANTITY:_____ **DO YOU DRINK ALCOHOL? Y/N QUANTITY:**_____