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 #:___________________________(Cell # Used for Portal Access)

E-MAIL ADDRESS:____ MAY WE EMAIL YOU? YES_____ NO____

EMERGENCY CONTACT:____ RELATION TO PATIENT:______________

PHONE#:__________________________ E-MAIL ADDRESS:____

PATIENT'S EMPLOYER:___________________________________ OCCUPATION:____________________________

EMPLOYER ADDRESS:____

WORK #:__________________________

PREFERRED PHARMACY:____ ZIP CODE: __________________

PRIMARY INSURANCE SECONDARY INSURANCE

INS. COMPANY NAME:___________________________________ __________________________________

<u>FOR PATIENTS UNDER THE AGE OF 18, WE REQUIRE THE GUARDIAN'S INFORMATION BELOW:</u>

FULL NAME:____ RELATIONSHIP TO PT.:_____________________

DOB:________________ SS#________________________ PHONE #__________________________

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

ADDRESS (IF DIFFERENT THAN PT):____

DO YOU HAVE VISION INS.? YES__NO__ Vision Ins. Carrier: _____________________ ID#__________________

MEDICAL DR NAME:______________________________________ MEDICAL DR PHONE #:_____________________

WHO REFERRED YOU TO OUR OFFICE?____

Our office performs <u>medical examinations</u> and bills through your <u>medical</u> insurance. If you have a Vision Insurance Plan, we must be notified at EVERY visit that you would like to use your Vision 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), <u>you will be</u> 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:_______________