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## Patient Information

*Thank you for choosing Valley Eye Associates for your eyecare needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help you.*

Name Last First MI			Today's Date / /		Sex F M <input type="checkbox"/> <input type="checkbox"/>		
Social Security # -- --		Date of Birth / /		Age		E-mail Address	
Street Address			City		State		Zip Code
Home # ( )		Work # ( )		Cell # ( )		Would you like to receive text confirmations: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you prefer to receive calls at: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		Race: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian <input type="checkbox"/> Caucasian <input type="checkbox"/> Pacific Islander			Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed		
Employer Name & Address					Position/Department		
Spouse/Parent's Name					Spouse/Parent's Work/Cell Phone ( )		
Student <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes: Name of School			City		State	
Emergency Contact			Phone ( )		Whom may we thank for referring you to us?		
<b>Guarantor (Person Financially Responsible) – if Self: Skip this section</b>							
Name			Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other		Phone ( )		
Street Address			City		State		Zip Code
<b>Medical Insurance Information</b>							
Primary Insurance	Primary Policy Holder	Member ID	Primary's SS #		Primary's Date of Birth / /		
Secondary Insurance	Primary Policy Holder	Member ID	Primary's SS #		Primary's Date of Birth / /		

# Patient Medical History & Review of Systems

Medical Doctor: \_\_\_\_\_ Medical Doctor's Phone: \_\_\_\_\_

Date of Last Physical: \_\_\_\_\_ Date of Last Eye Exam: \_\_\_\_\_

## Chief Complaint:

How can we help you today? In this space, please briefly tell us any signs and symptoms you are experiencing. (Medical insurance will only cover your visit if there is a medical reason for the exam such as loss of vision, headaches, eye redness, eye pain, floaters, dry eye, eye itching or burning, glaucoma, cataracts, etc)

## History of Present Illness:

Location	Which eye has the problem?	<input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye <input type="checkbox"/> Both Eyes
Quality	Does the problem cause vision loss or blur?	<input type="checkbox"/> Loss <input type="checkbox"/> Blur
Context	Did the problem occur suddenly or gradually?	<input type="checkbox"/> Sudden <input type="checkbox"/> Gradual
Severity	How severe is the problem?	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Modifying Factors	Is it worse at any specific distance?	<input type="checkbox"/> Distance <input type="checkbox"/> Near <input type="checkbox"/> Both
Duration	How long does the last?	<input type="checkbox"/> Intermittent <input type="checkbox"/> Constant
Timing	How long has the problem been occurring?	<input type="checkbox"/> Short Term <input type="checkbox"/> Long Term
Associated Symptoms	Are there associated symptoms?	<input type="checkbox"/> No <input type="checkbox"/> Headaches <input type="checkbox"/> Nausea
Previous Interventions	Does anything help the problem?	<input type="checkbox"/> Nothing helps <input type="checkbox"/> Nothing has been tried

Are you thinking of getting GLASSES today?  Yes  No

Are you thinking of getting CONTACTS today?  Yes  No

Do you currently wear glasses?  Yes  No

When do you wear your glasses?

- All the Time  Reading/Near Work  Computer Work  
 Work Safety  Distance Tasks Only  Driving  
 Other, please explain \_\_\_\_\_

Have you ever worn contacts?  Yes  No

If yes: Brand: \_\_\_\_\_ Contact Lens Solution Used: \_\_\_\_\_

Are you interesting in wearing contact lenses?  Yes  No

If so, what style?

- Soft  Gas Permeable  Extended Wear  Bifocal  
 Color  Disposable  Astigmatic  Unsure

Do you work at a computer or video display terminal?  Yes  No

In which hobbies or sports do you participate? \_\_\_\_\_

Please Check any of the following conditions that apply to you:

- Allergies (seasonal)  Allergies (environmental)  Drug Allergies (please list on next page)  
 Pregnant  Have given birth in the last 6 months  Breastfeeding  Sinus Trouble

Please list current medications:

NAME	DOSAGE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies: \_\_\_\_\_

Please list any major surgeries or hospitalizations: \_\_\_\_\_

Please **check** 'yes' or 'no' for each question and write in any essential information:

<b>PAST OCULAR HISTORY</b>	Yes	No	<b>FAMILY OCULAR/MEDICAL HISTORY</b>	Yes	No
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Laser Treatments	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chemo/Radiation	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Severe Ocular Pain	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
Sensitivity to Light	<input type="checkbox"/>	<input type="checkbox"/>			
Floaters or Spots	<input type="checkbox"/>	<input type="checkbox"/>	<b>SOCIAL HISTORY</b>		
Flashes of Light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Smoking		
Poor Distance Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____ packs/day _____ years		
Poor Near Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Alcohol		
Eye Infection or Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> social <input type="checkbox"/> occasional <input type="checkbox"/> heavy		
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____ drinks/day		
Eye Burn, Itch, or Water	<input type="checkbox"/>	<input type="checkbox"/>			
Eye Strain	<input type="checkbox"/>	<input type="checkbox"/>			
Other: _____					

**Review of Systems:**

Please **check** 'yes' or 'no' for each question and write in any essential information:

<b>CONSTITUTIONAL</b>	Yes	No	<b>ENDOCRINE</b>	Yes	No
Check 'yes' if you currently have			Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Flu	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	If yes, year diagnosed: _____		
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Last Blood Sugar measured: _____		
Headache	<input type="checkbox"/>	<input type="checkbox"/>	Type I <input type="checkbox"/> Type II <input type="checkbox"/>		
Recent Weight Change	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
<b>EAR, NOSE, THROAT</b>	Yes	No	<b>GENITOURINARY</b>	Yes	No
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Throat	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>

**CARDIOVASCULAR**                      Yes    No  
 Chest Pain                                     
 Palpitations                                    
 High Blood Pressure                         
 High Cholesterol                             
 Heart Failure                                   
 Pacemaker                                     
 Heart Attack                                    
 Angioplasty/Bypass                         
 Valve Disease                                  
 Carotid Artery Disease                  

**RESPIRATORY**                        Yes    No  
 Shortness of Breath                         
 Asthma                                           
 Emphysema                                    
 Cough                                            
 Bronchitis                                     
 Pneumonia                                     
 Tuberculosis                                

**HEMATOLOGIC**                        Yes    No  
 Anemia                                           
 Sickle Cell                                     
 Bleeding Abnormality                     
 Elevated Cholesterol                  

**MUSCULOSKELETAL**                Yes    No  
 Joint Pain                                      
 Rheumatoid Arthritis                     
 Back Pain                                      
 Fractures                                      
 Marfan's Syndrome                        
 Ankylosing Spondylitis              

**CANCER**                                Yes    No  
                                  
 If yes, type: \_\_\_\_\_

**NEUROLOGICAL**                        Yes    No  
 Stroke                                           
 Weakness                                      
 Seizure                                         
 Multiple Sclerosis                      

**SKIN**                                      Yes    No  
 Rash                                             
 Itch                                              
 Lesion                                           
 Growth/Tumors                          

**PSYCHIATRIC**                        Yes    No  
 Dementia                                      
 Alzheimer's                                   
 Depression                                    
 Anxiety                                         
 Schizophrenia                              
 Bipolar                                      

**GASTROINTESTINAL**                Yes    No  
 Heartburn                                     
 Bowel Problems                             
 Inflammatory Bowel Disease            
 Gall Bladder Problems                    
 Hepatitis                                   

**IMMUNOLOGY**                        Yes    No  
 Immune Deficiency                        
 Lupus                                           
 Sjogren's                                      
 Other: \_\_\_\_\_

**HIV EXPOSURE**                        Yes    No  
                               

**STD EXPOSURE**                        Yes    No  
                                  
 If yes, type: \_\_\_\_\_

**Authorization:**

*I certify that I have read and understood the above information to the best of my knowledge. I certify that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and/or health practitioners.*

X \_\_\_\_\_  
 Signature of Responsible Party

\_\_\_\_\_  
 Date

## **Agreement of Responsibility**

### **WAIVER OF RESPONSIBILITY**

I understand there are risks associated with using my own frame and that Valley Eye Associates is not responsible for any damage done during adjustments or insertion of new lenses.

### **FINANCIAL POLICY-SIGNATURE ON FILE FORM**

We make every effort to keep down the cost of your medical care

- All fees are due the same day services are rendered or that the materials are ordered
- We accept the following forms of payment: Cash, Checks, Master Card, Visa, American Express, and Discover
- The patient who seeks care is responsible for the payment of all fees
- The person bringing the child into the office is responsible for the payment of all fees.
- Additional fees for administrative services apply. These fees may include, but are not limited to, fees for medical records as allowed by law, fees for non-covered services rendered and fees for the completion of forms you may request.
- If an appointment is cancelled with less than 24 hours' notice, a cancellation fee will be applied to the patient's account
- If an attorney's services are required or if it is necessary to resort to small claims court, the patient will be required to pay the attorney's fees and the costs of court in addition to paying the amount due or ordered by the court.

### **PATIENTS WITH THIRD PARTY PLANS**

I authorize my third party plan to pay Valley Eye Associates directly. If this is not permitted by my policy then send the check made out to Valley Eye Associates at the following address:

Valley Eye Associates  
219 Old Hook Road  
Westwood, NJ07675

I authorize Valley Eye Associates to file complaints on my behalf if my third party carrier does not properly handle my claim. In order to ensure payment of my claim, I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

### **PATIENT CONSENT FORM**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in a treatment, both directly and indirectly.
- Obtain payment from third party payers.
- Conduct routine healthcare operations, such as quality assessments and physical certifications.

I have been informed by Valley Eye Associates and the Notice of Privacy Practices (see forms below) which contains a more detailed description of the uses and disclosures of my health information. I have been given the right to review and sign this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that Valley Eye Associates restricts how my private information is used or disclosed to carry out treatment, payment, or health care options. I also understand that Valley Eye Associates is not required to agree to my request restrictions, but if Valley Eye Associates does agree then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, excluding the extent in which Valley Eye Associates has already taken action relying on this consent.

Patient's Name (OR Responsible Party) \_\_\_\_\_

Signature of Patient (OR Responsible Party) \_\_\_\_\_

Date \_\_\_\_\_

# Payment Policy

Patients who have insurance coverage that Valley Eye Associates **participates** with:

Valley Eye Associates participates with most insurance companies, but each plan varies by employer and insured. **Please know your plan.** Co-payments are due and payable at the time of your office visit. Deductibles, co-pays, co-insurances, and/or other balances that are your responsibility will be billed to you once these amounts are determined. If you are a member of an HMO, you are required by your plan to obtain a referral prior to your medical examination here.

If your plan requires a referral and you have not obtained one, your examination may need to be rescheduled.

**You must present your insurance card at the time of your visit.** If you do not have your insurance card your examination may need to be rescheduled.

Patients who have insurance coverage that Valley Eye Associates does **not participate** with:

You will be required to pay out of pocket at the time services are rendered. Please contact the physician and/or the office manager to discuss a payment plan, if necessary.

Patients who are **not covered** by insurance:

We require payment at the time services are rendered. Please contact the physician and/or the office manager to discuss a payment plan, if necessary before seeing the doctor.

Patients, who fail to provide **accurate insurance** information at the time services are rendered, will have seven (7) days to provide Valley Eye Associates the accurate insurance information. Failing to do so will result in full financial responsibility.

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

## **Payment Arrangements are requested at the time of your visit.**

We offer the following payment options:

Payment by cash

Payment by check

Payment by credit card

Automatic monthly billing to your Visa or Master Card

Guarantee any amount not covered by insurance with Visa or Master Card

Please make your choice and sign below. If none of the above apply, please see the office manager. Thank you.

Our office is fully approved and accredited user of the Visa and Master Card Health Care Program which will enable you to use your Credit Card to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Credit Card on a monthly basis.

I authorize the release of information to determine liability for payment and/or to obtain reimbursement. I understand that if my account is not paid directly, I am responsible for the full amount and may be charged all costs including attorney/collection agency fees incurred with collection of the amount due.

I authorize the release of any medical information necessary to process claims and the release of payment to Valley Eye Associates or the physician rendering services.

Patient's Signature (Or Responsible Party): \_\_\_\_\_

Date: \_\_\_\_\_