

220 Hamburg Turnpike, Suite 7
Wayne, NJ 07470



10 West Hanover Ave, Suite 103
Randolph, NJ 07869

New Patient Questionnaire

Patient Full Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Social Security #: _____ - _____ - _____

Date of Birth: _____ Age: _____ Sex: M F

Email: _____ Marital Status: S M D W

Primary Care Physician: _____

Pharmacy: _____

Who may we thank for referring you to our office? _____

Person Responsible for this account? (Parent/Guardian): _____

Relationship to Patient _____ Date of Birth: _____

Phone Number: _____ Social Security #: _____ - _____ - _____

Patient Place of Employment: _____ Phone: _____

Employer: _____ Occupation: _____

Are you here regarding a work related injury? _____

In case of an Emergency, who should be notified: _____

Relationship to Patient: _____ Phone Number: _____

I authorize the release of any medical information to process all claims. I further authorize the release of payment for medical benefits to Advanced Eye Care Center, P.A.

Patient's Signature: _____

Do you wear glasses? YES NO

Do you wear contact lenses? YES NO

If yes, please list brand, base curve "B.C." and power:

Right eye: _____ Left eye: _____

Does the **PATIENT** have or ever been told of the following **EYE** conditions:

Glaucoma? YES NO If Yes, how long? _____ (list medications below)

Cataracts? YES NO If Yes, when diagnosed? _____ (list surgery below)

Diabetic Retinopathy? YES NO If Yes, how long? _____ Treatment? _____

Macular Degeneration? YES NO If Yes, how long? _____ Treatment? _____

Keratoconus? YES NO If Yes, how long? _____ Do you wear contacts? _____

Corneal Dystrophy? YES NO If Yes, how long? _____ (list medications below)

Dry Eye Syndrome? YES NO If Yes, how long? _____ (list medications below)

Do you take any **EYE** medications? (Eye drops?) YES NO If yes, please list below:

_____ times per day

_____ times per day

_____ times per day

Have you ever had any **SURGERY** on your **EYES**? YES NO If yes, please list below:

If yes, Please list type of surgery and date(s): _____

Is there any **FAMILY HISTORY** of the following **EYE** conditions? Glaucoma Keratoconus

Macular Degeneration Diabetic Retinopathy Cataract Corneal Dystrophy

Other – Please Explain: _____

Does the **PATIENT** have any of the following **medical conditions**? (check all that apply)

Diabetes-how long? _____ High blood pressure High Cholesterol Heart Disease Thyroid

Carotid Artery Stroke Ear/Nose/Throat Problems Rheumatoid Arthritis Cancer

Other: _____

Please list previous **surgery/surgical procedures**: _____

MEDICATIONS: (please *provide a list*, or list names and dosages below): _____

ALLERGIES: (Please list all drug and food allergies): _____

Do you smoke? YES NO If yes, how much? _____

Do you drink alcohol? YES NO If yes, how often? _____

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**VISION PLAN VS. MEDICAL INSURANCE POLICY:
(Davis Vision, VSP or Eyemed)**

Davis Vision, VSP and EyeMed are limited optical benefits. They are **NOT** medical insurance plan.

Your vision plan coverage provides for an optical and contact lens benefit. It also includes a limited eye examination of the *normal eye*. It does **NOT** provide for discussion, treatment or additional testing of any ocular pathology (abnormal findings).

All examinations at Advanced Eye Care Center, P.A. are performed by a Medical Doctor (M.D.), Board-Certified in Ophthalmology (Medicine and Surgery of the Eye). A comprehensive evaluation will be performed.

If you are having eye related symptoms (for example: redness, eye irritation, tearing, headache or blurred vision not correctable by glasses) or an *abnormal finding is uncovered during the course of your examination* (you may not be aware of such findings), your eye examination and additional testing, if performed, will be billed to your major medical plan. Your vision benefit may be applied to the cost of the refraction (measurement to determine a change in prescription), a service which may not be covered by your medical insurance. Your medical plan may require you to pay a copayment and coinsurance depending on the plan.

Your benefit towards eyeglass and contact lens will be the same regardless of the presence of ocular pathology.

I authorize Advanced Eye Care Center to bill my medical insurer if my eye examination reveals any eye abnormality or disease. I understand that I will be responsible for any copayment or coinsurance as required by my medical insurance company.

Patient Name

Date



Charles Reing, MD

Nancy Choo, MD

Bryan Abessi, MD

Geeta Garg, MD

David Freilich, MD

Board Certified Ophthalmologists

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HIPAA RELEASE FORM

- I authorize the release of my medical records and information including the diagnosis, examination, and claims information to the following:

Name	Relationship	Phone #
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Name	Relationship	Phone #
------	--------------	---------

Name	Relationship	Phone #
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- I DO NOT authorize the release of my medical records.

I acknowledge Advanced Eye Care Centers Notice of Privacy Practices.

I am aware the Privacy Act is available upon my request.

PRINT Patient's Name: _____ Date: _____

Signature: _____

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OFFICE POLICIES REGARDING INSURANCE PLANS AND REFERRALS

We understand that many changes in the healthcare systems have made it quite confusing for our patients. The following are guidelines that have been established by the insurance companies to allow for reimbursement for the services we provide.

- **YOU** are responsible for obtaining and bringing referrals **at the time service is rendered**.
- Primary care physicians have indicated that they cannot be called with a patient in the office for a referral for that particular visit. Referrals must be obtained **before** your visit in our office. Primary care physicians often need several days to provide you with the referral.
- Referrals **do** expire; most are good for either sixty or ninety days. This is clearly indicated on referral forms.
- **If a referral is required and not obtained by the patient and the claim is denied, you are fully responsible for payment.**
- You are responsible for your co-payment at the time treatment is rendered.
- **In addition to your co-pay there is a charge for a refraction. A refraction is a check for eyeglass prescription. Many insurances consider this to be a “non-covered” service. You will be responsible for the \$50.00 fee if your insurance company denies it.**
- A consultation report will be sent to your Primary care doctor after the first visit and follow-up reports will be provided as necessary.
- We are always available to help you with any questions regarding your treatment in our office. If you have a specific question regarding your insurance, please contact them directly. The number is located on the back of your insurance card.

I have read and understand the above,

Print Patient's Name: _____ Date: _____

Signature: _____