220 Hamburg Turnpike, Suite 7
Wayne, NJ 07470

ADVANCED EYE CARE CENTER

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:_____

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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

ADVANCED EYE CARE CENTER

Charles Reing, MD Nancy Choo, MD Brian Chon, MD Geeta Garg, MD Jing Jing Feng, M.D.

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 #

_____

Name Relationship Phone #

_____

Name Relationship Phone #

❑ 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:_____