New Patient History

Patient First Name: _____ Last Name_____ Date:_____

Reason for TODAY'S Visit

Routine Eye Exam Yes / No Eye Irritation Yes / No
Need/Want Glasses Yes / No Sunglasses Yes / No
Need/Want Contacts Yes / No
Lasik-Laser Vision Correction Evaluation Yes / No Need more info? Yes / No
Are there any issues or concerns that you would like to address with the Doctor today:
_____
_____

Do you work on a computer? Yes / No
How many hours per day? _____
Do you have sunglasses? Yes / No
Sports/Hobbies _____
_____
Do you have specific visual needs that need to be addressed? Yes / No
Explain_____

OCULAR HISTORY

Date of last **EYE EXAM** _____ Doctor _____ Town_____
Do you or have you worn glasses? Yes / No Type: **Single Vision** Near/Distance/Both **Bifocal** **Progressive**
Do you or have you worn Contacts? Yes / No Type: Soft / Astigmatic / Bifocal / Gas Perm
Current Contact Lens Wearers:
Brand of Contacts_____ Type of Disinfection/solution _____
Average Wearing time _____ If extended wear, how many days?_____
How frequently do you replace your lenses? _____
Are you interested in Contact Lenses? Yes/ No Why?_____
Do you experience red, dry, irritated or itchy eyes? Yes / No Are you using artificial tear drops? Yes / No
Which eye drops are you using? _____ How many times a day? _____
Have you ever experienced or been told you have any of the following?

☐ Cataracts	☐ Double Vision	☐ Flashes / Floaters	☐ Color Blindness
☐ Glaucoma	☐ Sudden Vision Loss	☐ Eye Turn / Lazy Eye	☐ Intermittent Blurred Vision
☐ Retinal Disease	☐ Eye / Head Injury	☐ Vision Therapy / Eye Exercise	☐ Other _____

Have you ever had eye surgery? For what condition & when? _____

PHYSICAL HISTORY

Date of Last **PHYSICAL EXAM** _____ Doctor_____Town_____
Specialty Physician _____ Specialty _____Town _____
Specialty Physician _____ Specialty _____Town _____
Would you like a report of todays exam sent to you physician? Yes / No If so which one? _____
Are you a diabetic / pre-diabetic? Yes / No Last A1c _____ Date of Bloodwork? _____
Last Home testing? _____ What was the blood glucose reading _____
Do you have High Blood Pressure? Yes / No Are you a smoker? Yes / No How many packs a week? _____
Do you drink alcohol? Yes / No If so how frequently? Daily / Weekly / Occasionaly
Do you have any allergies? Yes / No If so, to what?_____
Women: Are you pregnant? Yes / No How many weeks?_____ Are you Nursing Yes / No

Systemic Disorders (Please indicate if you or a blood relative has any condition below) **S=Self F=Family**

S / F	Asthma/Lung Disease	S / F	Migraine Headaches	S / F	Autoimmune Disease (Lupis, Chrone's)
S / F	Heart/Vascular Disease	S / F	Fainting Dizziness	S / F	Skin Disease / Conditions
S / F	Intestinal/Digestive Problem	S / F	Rheumatiod Arthritius	S / F	Cancer - Type _____
S / F	Thyroid Disease	S / F	High Cholesterol	Other _____	

Many systemic medications affect your vision and the health of your eyes. Please list your medications below or allow us to copy your list.
_____

This information is confidential and was given by: _____ Date _____

New Patient Registration

Patient Information

Mr./Mrs/Ms/Dr/_____

First Name_____ MI_____Last Name_____ Jr/Sr/III/IV/_____

Date of Birth _____/_____/_____ Social Security Number _____ /____ /_____ MD/DO/DMD/CNP/____

Address _____

City _____ State _____ Zip Code_____

Do you have a second (Winter / Summer) Address? Approximate dates of use? _____

Secondary Address _____

City_____ State _____ Zip code _____

Contact Information

Home Phone_____ Cell Phone _____

Work Phone_____ Email_____

Where do you prefer to receive telephone calls? Home Cell Work

May we leave messages on your home/cell voicemail? _____ May we leave messages for you at work?_____

May we Email you? _____ Do you want to receive text reminders? _____

Patient Status

Marital Single/Married/Widowed/Other Spouse's Name _____

Employment Employed Full Time/Part Time Employer / School _____

Student Full Time/Part Time Position_____

Not Employed Retired City_____ State_____ Zip_____

Physician & Insurance

Primary Care Physician _____ City_____ State_____ Phone_____

Specialty Physician _____ City_____ State_____ Phone_____

If you have insurance, who is the insured?

Name _____ Relationship: Self / Spouse / Parent / Other_____

Address_____ City_____ State_____ Zip _____

Date of Birth___/___/____ Social Security Number_____/___/_____ Telephone _____

PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. A $20 (TWENTY DOLLAR) BILLING CHARGE WILL BE APPLIED TO ALL OUTSTANDING BALANCES, UNLESS PRIOR ARRANGEMETNS HAVE BEEN MADE. THE RETURNED PAYMENT FEE IS $30 (THIRTY DOLLARS). PATIENTS ARE RESPONSIBLE FOR ALL COSTS ASSOCIATED WITH COLLECTIONS AND LEGAL ACTIONS. THERE WILL BE A $30 (THIRTY DOLLAR) "NO-SHOW" CHARGE FOR NOT KEEPING APPOINTMENTS UNLESS WE HAVE BEEN NOTIFIED 24 HOURS IN ADVANCE OF THE APPOINTNED TIME.

Who may we thank for referring you? _____

Insurance coverage can be very confusing and frustrating to both you and our staff. Because of this we ask that you please provide all insurance cards and coverage so that our staff can determine the most appropriate coverage for your visit. There are several types of coverage: medical insurance, vision Insurance, and vision discount plans. We will bill the most appropriate plan depending on your presenting symptoms, complaints and medical history.

Vision Plans - (Ex. VSP, VBA, Eyemed, Davis Vision, etc.)
Some of these plans pay part (or occasionally) all of the services and some are discounted fee only plans. Coverage includes a refraction to determine your eyeglass prescription and a screening for eye disease / disorders. Some may include coverage for contact lens services and / or glasses. The examination for contact lenses is optional and not part of the routine vision examination. There is an additional charge to be fit for contact lenses and it may or may not be covered by your vision plan - usually it will have an additional co-pay if it is covered. Vision plans do not cover medical conditions of the eye.

Medical Coverage - *what is a medical eye exam?*
If you are having a problem with your eyes other than a change in vision then your examination will be billed medically. Some medical problems could cause blurred vision. If the doctor finds that a medical condition is causing your vision problem, then your examination will be billed medically. Many pre-existing conditions such as cataracts, glaucoma, diabetes, dry eye, etc. will require a medical examination. If your medical insurance requires a referral than it is your responsibility to obtain one before we will treat you.

**Some Medical Insurance plans do provide a annual wellness eye examination.
Companies such as Horizon - NJ Direct, Aetna, Amerihealth, and others ***may*** provide a routine refraction and eye health screening. If you also have a vision plan it will be at our discretion as to which plan gets billed for the examination. We will consider the complexity of your exam, as well as insurance company rules and regulations to determine which plan will be billed. Your vision insurance plan or the discount plan will be used for any eyewear that you purchase.

Why is this so complicated? We ask ourselves this same question daily! We are legally obligated to follow the rules and reguletions set forth by your insurance company and the state.

Confused? We will try to answer any questions that you may have about your insurance coverage, but you may need to consult with your insurance company or human resorces department. Remember, your insurance is a contract between you the subscriber, and your insurance company. There are hundreds of insurance companies and plans and we are not experts on all the rules and regulations for every company.

Please acknowledge the above statements regarding your Vision Plan / Medical Insurance / Vision Discount Plan and its limitations. You have the opportunity to ask questions, and understand that you are responsible for any professional services you may receive today.
Payment is expected at the time services are rendered.

Signed: _____ **Date:** _____

Insurance Policy

Your insurance coverage is a contract between you and your insurance company. It is up to **you** to **know your policy**. Even with a referral your insurance company may not pay and your services not be covered. You will be financially responsible for services rendered if your insurance company denies payment to us. If you have any questions, please call your insurance company directly.

It is your responsibility to obtain any and all referrals. Referrals cannot be backdated, as this is insurance fraud. If you do not have a referral, and one is required by your insurance policy, **you are expected to pay for your visit at the time of service**. We will supply you with a receipt so that you may apply for reimbursement from your insurance company.

We accept assignment from many insurance companies. The companies pay a percentage of the approved amount. It is the patient's (guarantor's) obligation and the law that you pay any remaining deductible and balance between the approved amount and the amount paid by the insurance company. If for any reason your insurance company does not pay for your visit, it then **BECOMES YOUR RESPONSIBILITY**. It is your responsibility to know the contract between you and your insurance company. Please provide us with all the necessary information needed to processes your claim.

Primary Vision Insurance

Company: VSP / VBA / Eyemed / Davis _____

Insured's Name _____ Patient's Relationship to Insured : Self / Spouse / Child _____

Policy # _____ Insured's DOB:_____ SS #_____

Secondary Vision Insurance

Company: VSP / VBA / Eyemed / Davis _____

Insured's Name _____ Patient's Relationship to Insured : Self / Spouse / Child _____

Policy # _____ Insured's DOB:_____ SS #_____

Primary Medical Insurance

Company: Horizon / Medicare / Aetna _____

Plan Name _____ Policy # _____ Group #_____

Patient's Relationship to Insured Self / Spouse / Child / Oher _____

Insured's Name _____ Insured's DOB:_____SS#_____

Secondary Medical Insurance

Company : _____

Plan Name _____ Policy # _____ Group #_____

Patient's Relationship to Insured Self / Spouse / Child / Other _____

Insured's Name _____Insured's DOB:_____SS#_____

We will directly bill your insurance company as a courtesy to you only when the below criteria have been met:

1. Benefits must be verified by our office **prior** to any service.
2. Patient liability must be paid at time services are rendered.

For those companies that we do not have a contract with, payment for services must be **paid for in full** at time of service.

I have read, understand and will comply with the above mentioned Insurance Policies.

Signature _____ Date _____

insurance companies state that we must have on file your signature for release of records and authorizing payments. Please sign and date in the boxes below.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process a claim for services rendered. I also request payment of benefits to either myself or the party who accept assignment of benefits

Signature _____ Date _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical/optical benefits to Elite Eyecare Associates/Dr. J. Scot Ellis, O.D. for Optometric and Optical Services

Signature _____ Date _____