219 Old Hook Road
Westwood, NJ 07675
Office: (201) 664 - 0847
Fax: (201) 664 – 8890
E-Mail: Mail@2020nj.com

Patient Information

Thank you for choosing Valley Eye Associates for you 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 ☐

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:
( )	( )	( )	☐ Yes ☐ No

Do you prefer to receive calls at:	Race:	Marital Status
☐ Home ☐ Work ☐ Cell	☐ African American ☐ Asian ☐ Hispanic ☐ American Indian ☐ Caucasian ☐ Pacific Islander	☐ Married ☐ Divorced ☐ Single ☐ Widowed

Employer Name & Address	Position/Department

Spouse/Parent's Name	Spouse/Parent's Work/Cell Phone
	( )

Student	If Yes: Name of School	City	State
☐ Yes ☐ No			

Emergency Contact	Phone	Whom may we thank for referring you to us?
	( )	

Guarantor (Person Financially Responsible) – if Self: Skip this section

Name	Relationship to Patient	Phone
	☐ Self ☐ Parent ☐ Spouse ☐ Other	( )

Street Address	City	State	Zip Code

Insurance Information

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

PAST OCULAR HISTORY	Yes	No
Glaucoma	☐	☐
Cataracts	☐	☐
Macular Degeneration	☐	☐
Diabetic Eye Disease	☐	☐
Retinal Detachment	☐	☐
Lazy Eye	☐	☐
Eye Surgery	☐	☐
Laser Treatments	☐	☐
Eye Injury	☐	☐
Chemo/Radiation	☐	☐
Severe Ocular Pain	☐	☐
Sensitivity to Light	☐	☐
Floaters or Spots	☐	☐
Flashes of Light	☐	☐
Poor Distance Vision	☐	☐
Poor Near Vision	☐	☐
Eye Infection or Disease	☐	☐
Double Vision	☐	☐
Eye Burn, Itch, or Water	☐	☐
Eye Strain	☐	☐

Other: _____

FAMILY OCULAR/MEDICAL HISTORY	Yes	No
Glaucoma	☐	☐
Cataracts	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Diabetes	☐	☐
Thyroid Problems	☐	☐
Heart Disease	☐	☐
Cancer	☐	☐

Other: _____

SOCIAL HISTORY

☐ Smoking

_____ packs/day _____ years

☐ Alcohol

☐ social ☐ occasional ☐ heavy

_____ drinks/day

Review of Systems:

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

CONSTITUTIONAL	Yes	No
Check 'yes' if you currently have		
Flu	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Headache	☐	☐
Recent Weight Change	☐	☐

EAR, NOSE, THROAT	Yes	No
Hearing Problems	☐	☐
Sinus	☐	☐
Throat	☐	☐

ENDOCRINE	Yes	No
Thyroid	☐	☐
Diabetes	☐	☐

If yes, year diagnosed: _____

Last Blood Sugar measured: _____

Type I ☐ Type II ☐

Other: _____

GENITOURINARY	Yes	No
Prostate Problems	☐	☐
Kidney Stones	☐	☐
Hysterectomy	☐	☐

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
	☐	☐

STI 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.
- 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, NJ 07675

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.

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: _____