Retina Center of New Jersey, LLC

NEW PATIENT REGISTRATION FORM

First Name MI Last Name		Suffix	Sex: M / F
Home Address		Date of Birth	
City State Zip Code			
Preferred Language			
Ethnicity ☐ Hispanic Origin ☐ Not of Hispanic Origin	Race ☐ American Indian or Alaskan Native ☐ Black/African American ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Hispanic or Latino ☐ White		
Home #	Work #	Cell #	
Social Security #	Marital Status ☐ S ☐ M ☐ D ☐ W	E-mail	
Patients' Employer Name, Address / Occupation			
Emergency Contact Name	Phone #	Relationship	
Referring Physician/Group Name	Phone #	City	
Primary Care Physician	Phone #	City	
Financially responsible person (if different from patient)			
Responsible person's address:		Phone #	
***Are you currently residing in a Skilled Nursing Facility or Rehabilitation Center?		☐ Yes ☐ No	
If yes, name and address of facility		Phone #	
INSURANCE INFORMATION			
Primary Insurance:	Policy Holder Name:	DOB:	Sex: M / F
Address:			
ID #:	Group #:	Effective Date:	
Secondary Insurance:	Policy Holder Name:	DOB:	Sex: M / F
Address:			
ID #:	Group #:	Effective Date:	

FINANCIAL POLICY STATEMENT

Welcome to Retina Center of New Jersey. Thank you for choosing our practice for your medical care. We are committed to providing you with the highest quality services available. Please read and sign the following policy. If we are contracted with your insurance company, we will accept assignment. All co-pays, co-insurance and deductibles are due and payable at time of service. Failure to provide necessary referrals or current accurate billing information will result in all charges for services the sole responsibility of the patient/responsible party. You will be responsible for any balances not covered by your insurance. A return check fee of $35.00 will be assessed if your check is returned by your bank. Our cancellation and "no show" policy is as follows: First occurrence, patient will be charged a $25.00 fee. Second occurrence, patient will be charged a $35 fee. Third occurrence, patient will be charged a $50 fee. The patient may be charged the full price of the scheduled office visit for any additional "no show" or any appointment cancellation that occurs within 24 hours of a scheduled appointment.

Patient Signature_____ Date_____

HIPAA - This office will comply with all aspects as printed in our Notice of Privacy Practice, and our privacy notice will be in compliance with all appropriate laws and regulations.

PATIENT AUTHORIZATION

I hereby authorize Retina Center of NJ to apply for benefits on my behalf for services rendered. I request payments from Medicare, Medigap, and/or any other insurance company be made directly to Retina Center of NJ. I certify that the information I have provided on this form is correct. I authorize the release of any necessary information for this or any related claim to the above named carrier or in case of Medicare Part B benefits.

I hereby attest that I have been given and reviewed the Notice of Privacy Practice.

Patient Signature_____ Date_____

Retina Center
of New Jersey, LLC

HIPAA NOTICE OF PRIVACY PRACTICE

Privacy Consent

I understand that Retina Center of New Jersey, LLC, "Notice of Privacy Practices" provides how my health information will be used and disclosed. The "Patient Rights" section describes my rights under the law. I have the right to review the notice before signing this consent. I understand that this notice may change and that I can request a revised copy.

I understand that I have the right to request that we restrict how protected health information about me is disclosed for treatment, payment, or health care operations. I understand that Retina Center of New Jersey, LLC, is not required to agree to this restriction, but you will honor this agreement.

I acknowledge by signing this form I consent to your use and disclosure to protect health information about my treatment, payment, and health care operations. I have the right to revoke this consent in writing with my signature. However, this revocation shall not affect any disclosures Retina Center of New Jersey, LLC has already made in reliance prior to my consent. Retina Center of New Jersey, LLC, provides this form to me to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Consent to Release Information

I acknowledge that by signing this form, I permit Retina Center of New Jersey, LLC, to release any information to the physician involved in my care. I consent that Retina Center of New Jersey, LLC, may call my house or designate locations and leave a message on voice mail or in person in reference to my appointment reminders and insurance items. In addition, Retina Center of New Jersey, LLC, may mail to my home appointment reminders and patient statements.

I designate the following representative(s) who the Retina Center of New Jersey, LLC, can communicate with me on my by behalf. If you do not designate anyone, the doctor will be unable to speak to anyone in your family regarding your medical condition.

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Signature of Patient or Legal Guardian_____Date_____

Print Name_____

Signature on file

I request that the payment of authorized benefits be made on my behalf to RETINA CENTER OF NEW JERSEY, LLC.

I authorize any holder of medical information about me be released to Novitas Medicare Solutions or any other of my medical carriers and any information needed to determine benefits or benefits payable for related services.

Signature of Patient or Legal Guardian_____ Date_____

Print Name_____

Retina Center of New Jersey, LLC

Date: _____ Date of Birth: _____

Name: _____ Height: _____ Weight: _____

NEW PATIENT MEDICAL HISTORY FORM

CHIEF COMPLAINT:

Patient is experiencing:

_____

_____

_____

HISTORY OF PRESENT ILLNESS:

Please describe your symptoms in your own words:

_____

_____

Reason for your referral:

_____

_____

Location: What is the site of the problem/which eye? _____

Unilateral (one eye) ☐ Bilateral (both eyes) ☐

Quality: What is the nature of the pain? _____

Constant ☐ Acute ☐ Chronic ☐ Improved ☐ Worsening ☐

Severity: Describe your pain or redness (for example, on a scale of 1 to 10, with 10 being the worst) _____

Duration: How long has the problem been an issue? _____

Timing: Is the problem worse in the morning, evening, or is it constant? _____

Context: Is it associated with an activity? _____

Modifying factors: What efforts has the patient made to improve the problem (i.e. heat, artificial tears, other?) _____

Associated Signs and Symptoms: Is the problem causing blurred vision? _____

Headache ☐ Twitching ☐ Excessive Tearing ☐

REVIEW OF SYSTEMS

RESPIRATORY

Chronic or Frequent Cough ☐ Yes ☐ No
Spitting up Blood ☐ Yes ☐ No
Shortness of Breath ☐ Yes ☐ No
Asthma or Wheezing ☐ Yes ☐ No
Shortness of Breath While Walking or Lying ☐ Yes ☐ No
Recent Upper Respiratory Infection ☐ Yes ☐ No
Sleep Apnea ☐ Yes ☐ No

PSYCHIATRIC

Memory Loss or Confusion ☐ Yes ☐ No
Nervousness ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Insomnia ☐ Yes ☐ No

HEMATOLOGIC/LYMPHATIC

Slow to Heal After Cuts ☐ Yes ☐ No
Bleeding or Bruising Tendency ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
Phlebitis ☐ Yes ☐ No
Past Transfusion ☐ Yes ☐ No
Enlarged Glands ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No
Transfusion Reaction ☐ Yes ☐ No

CONSTITUTIONAL SYMPTOMS

Good General Health Lately ☐ Yes ☐ No
Recent Weight Change ☐ Yes ☐ No
Fever ☐ Yes ☐ No
Fatigue ☐ Yes ☐ No
Headaches ☐ Yes ☐ No
Insomnia ☐ Yes ☐ No

Hours of Sleep Each Night _____

CARDIOVASCULAR

Heart Trouble ☐ Yes ☐ No
Chest Pain ☐ Yes ☐ No
Angina Pectoris ☐ Yes ☐ No
Palpitations ☐ Yes ☐ No
No Heat or Cold Intolerance ☐ Yes ☐ No
Swelling of Feet or Ankles ☐ Yes ☐ No
Pacemaker ☐ Yes ☐ No
Myocardial Infarction ☐ Yes ☐ No
Hypertension ☐ Yes ☐ No
Heart Failure ☐ Yes ☐ No
Valve Disease ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
Irregular Rhythm ☐ Yes ☐ No
High Cholesterol ☐ Yes ☐ No
Peripheral Vascular Disease ☐ Yes ☐ No

MUSCULOSKELETAL

Arthritis ☐ Yes ☐ No
Joint Pain ☐ Yes ☐ No
Joint Stiffness or Swelling ☐ Yes ☐ No
Weakness of Muscles or Joints ☐ Yes ☐ No
Muscle Pain or Cramps ☐ Yes ☐ No
Muscular Disorder ☐ Yes ☐ No
Back Pain ☐ Yes ☐ No
Cold Extremities ☐ Yes ☐ No
Difficulty in Walking ☐ Yes ☐ No
Spine Disease ☐ Yes ☐ No
Fractures ☐ Yes ☐ No

INTEGUMENTARY

Rash or Itching ☐ Yes ☐ No
Change in Skin Color ☐ Yes ☐ No
Change in Hair or Nails ☐ Yes ☐ No
Varicose Veins ☐ Yes ☐ No
Breast Pain ☐ Yes ☐ No
Breast Lump ☐ Yes ☐ No
Breast Discharge ☐ Yes ☐ No
Skin Disorders ☐ Yes ☐ No

ENDOCRINE

Glandular or Hormonal Problems ☐ Yes ☐ No
Thyroid Disease ☐ Yes ☐ No
Excessive Thirst or Urination ☐ Yes ☐ No
Skin Becoming Dryer ☐ Yes ☐ No
Change in Hat or Glove Size ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
When were you diagnosed? _____

Type 1 or Type 2 (**please circle**)

HGB A1C/HbA1c? _____ Date: _____

Are You on Insulin ☐ Yes ☐ No
Times per day _____
Are You on Dialysis ☐ Yes ☐ No

EARS, NOSE, MOUTH AND THROAT

Hearing Loss or Ringing ☐ Yes ☐ No
Hearing Aids ☐ Yes ☐ No
Earaches or Drainage ☐ Yes ☐ No
Chronic Virus Problems ☐ Yes ☐ No
Rhinitis ☐ Yes ☐ No
Nose Bleeds ☐ Yes ☐ No
Mouth Sores ☐ Yes ☐ No
Bleeding Gums ☐ Yes ☐ No
Bad Breath or Bad Taste ☐ Yes ☐ No
Sore Throat or Voice Change ☐ Yes ☐ No
Swollen Glands in Neck ☐ Yes ☐ No

NEUROLOGICAL

Frequent Urination	☐ Yes ☐ No
Light Headed or Dizzy	☐ Yes ☐ No
Convulsions or Seizures	☐ Yes ☐ No
Numbness or Tingling	☐ Yes ☐ No
Tremors	☐ Yes ☐ No
Weakness or Paralysis	☐ Yes ☐ No
Stroke	☐ Yes ☐ No
Head Injury	☐ Yes ☐ No
Speech Difficulties	☐ Yes ☐ No
Change in Gait	☐ Yes ☐ No
Vision Difficulties	☐ Yes ☐ No
Glasses/Contact Lenses	☐ Yes ☐ No

NUTRITION

Supplements	☐ Yes ☐ No
Tube Feed	☐ Yes ☐ No
TPN	☐ Yes ☐ No
Eating Disorder	☐ Yes ☐ No
Vitamins/Minerals/Herbals	☐ Yes ☐ No
Liver Failure	☐ Yes ☐ No
Difficulty Swallowing	☐ Yes ☐ No
Unintentional Weight Loss In 3 Months	☐ Yes ☐ No

GASTROINTESTINAL

Loss of Appetite	☐ Yes ☐ No
Change in Bowel Movements	☐ Yes ☐ No
Nausea or Vomiting	☐ Yes ☐ No
Frequent Diarrhea	☐ Yes ☐ No
Painful Bowel Movements or Constipation	☐ Yes ☐ No
Rectal Bleeding or Blood in Stool	☐ Yes ☐ No
Abdominal Pain or Heartburn	☐ Yes ☐ No
Peptic Ulcer (Stomach or Duodenal)	☐ Yes ☐ No
Hiatus Hernia	☐ Yes ☐ No
Gastrointestinal Problems	☐ Yes ☐ No
Hemorrhoids	☐ Yes ☐ No
Pancreatitis	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No
Renal Disease	☐ Yes ☐ No

GENITROURINARY

Frequent Urination	☐ Yes ☐ No
Urination	☐ Yes ☐ No
Burning or Painful Urination	☐ Yes ☐ No
Blood in Urine (Change in Force or Stream)	☐ Yes ☐ No
Incontinence or Dribbling	☐ Yes ☐ No
Kidney Stones	☐ Yes ☐ No
Sexually Transmitted Disease	☐ Yes ☐ No
Sexual Difficulty	☐ Yes ☐ No
Male – Testicle Pain	☐ Yes ☐ No
Prostate Problems	☐ Yes ☐ No
Female- Pain with Periods	☐ Yes ☐ No
Female – Irregular Periods	☐ Yes ☐ No
HIV	☐ Yes ☐ No

PAST MEDICAL HISTORY

Medical Condition	Year of Onset

PAST SURGICAL HISTORY

Surgeries	Date

☐ Anesthesia Complications? Yes or No **(please circle)**

If yes explain:

_____

_____

CURRENT MEDICATIONS

Name	Dosage

PATIENT SOCIAL HISTORY

Marital Status	Use of Alcohol	Use of Tobacco	Use of Illicit Drugs	Excessive Exposure at Home or Work to:
☐ Single	☐ Never	☐ Never	☐ Never	☐ Fumes _____
☐ Married	☐ Rarely	☐ Previous But Quit	☐ Type & Frequency	☐ Solvents _____
☐ Divorced	☐ Moderate	☐ Currently	_____	☐ Chemicals _____
☐ Widowed	☐ Daily	_____ packs daily	_____	☐ Other _____

FAMILY MEDICAL HISTORY

	AGE	DISEASES	IF DECEASED, CAUSE OF DEATH
FATHER	_____	_____	_____
MOTHER	_____	_____	_____
BROTHER(S)	_____	_____	_____
	_____	_____	_____
SISTER(S)	_____	_____	_____
	_____	_____	_____
SPOUSE	_____	_____	_____
CHILDREN	_____	_____	_____

Advance Directive ☐ Yes ☐ No ☐ Would Like Information _____

PLEASE INFORM THE DOCTOR OF ALL PHYSICIANS YOU ARE CURRENTLY SEEING

	SPECIALTY	PHYSICIAN NAME	ADDRESS	PHONE NUMBER
1.	**Ophthalmologist**			
2.	**Optometrist**			
3.	**Internist**			
4.	**Endocrinologist**			
5.	**Cardiologist**			
6.	**Nephrologist**			
7.	**Neurologist**			
8.	**Podiatrist**			
9.	**Vascular Specialist**			
10.	**Other**			