Wyckoff Ophthalmology

Diseases & Surgery of the Eyes

Melanie Sinatra, M.D., F.A.C.S.
Diplomate of the
American Board of Ophthalmology

Patient Information

Name: _____ (First) _____ (Middle) _____ (Last) Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ Social Security #: _____ Race: _____ Ethnicity: _____ Language: _____

Home #: _____ Cell #: _____ Alternate #: _____

Email Address: _____ Preferred Contact #: _____

Employer: _____ Employer Phone #: _____

Pharmacy

Pharmacy Name: _____ Location: _____ Phone #: _____

Referral Source

Dr. _____ Internet : _____ Friend: _____ Other: _____

Insurance Information

Primary Insurance: _____ Group #: _____ Policy or ID #: _____

Insured Name: _____ DOB: _____ Social Security #: _____

Secondary Insurance: _____ Group #: _____ Policy or ID #: _____

Insured Name: _____ DOB: _____ Social Security #: _____

Responsible Party _____ Check if same as patient

Name: _____ (First) _____ (Middle) _____ (Last) DOB: _____ Relation: _____

Social Security #: _____ Phone #: _____ Employer: _____ #: _____

Responsible Address: _____ City: _____ State: _____ Zip: _____

Medical History - Circle or Check any that apply

☐ Anxiety	☐ Breast Cancer	☐ End State Renal Disease	☐ Hypercholesterolemia (High Cholesterol)	☐ Prostate Cancer
☐ Arthritis	☐ Colon Cancer	☐ GERD	☐ Hyperthyroidism	☐ Radiation Treatment
☐ Asthma	☐ COPD	☐ Hearing Loss	☐ Hypothyroidism	☐ Seizures
☐ Atrial Fibrillation (Irregular Heartbeat)	☐ Coronary Artery Disease	☐ Hepatitis	☐ Leukemia	☐ Stroke
☐ BPH	☐ Depression	☐ Hypertension (High Blood Pressure)	☐ Lung Cancer	Other _____
☐ Bone Marrow Transplantation	☐ Diabetes	☐ HIV / AIDS	☐ Lymphoma	Other _____

Surgeries

Name of procedure	Date of Surgery	Surgeon
1.		
2.		
3.		
4.		
5.		

Glasses and Contact Prescriptions

Glasses Prescription: Right Eye: _____ Left Eye: _____

Contact Prescription: Right Eye: _____ Left Eye: _____

Type of Contacts: ☐ Soft ☐ Toric ☐ RGP

Last time Contacts were worn: _____

Ocular History - Circle or Check any that apply

☐ Allergic Conjunctivitis	☐ Diabetic Retinopathy, Proliferative Right Eye	☐ Macular ERM Left Eye	☐ Strabismus Lazy Eye
☐ Blepharitis	☐ Diabetic Retinopathy, Proliferative Left Eye	☐ Narrow Angles Right Eye	☐ PVD Right Eye
☐ Cataract Right Eye	☐ Dry Eyes	☐ Narrow Angles Left Eye	☐ PVD Left Eye
☐ Cataract Left Eye	☐ Glasses	☐ Ocular Hypertension Right Eye	☐ Floaters Right Eye
☐ Contact Lenses	☐ Glaucoma Right Eye	☐ Ocular Hypertension Left Eye	☐ Floaters Left Eye
☐ Corneal Dystrophy Right Eye	☐ Glaucoma Left Eye	☐ Ophthalmic Migraine	Other _____
☐ Corneal Dystrophy Left Eye	☐ Macular Degeneration Right Eye	☐ Pseudoefoliation	Other _____
☐ Diabetic Retinopathy, Background Right Eye	☐ Macular Degeneration Left Eye	☐ Retinal Tear Right Eye	Other _____
☐ Diabetic Retinopathy, Background Left Eye	☐ Macular ERM Right Eye	☐ Retinal Tear Left Eye	Other _____

Ocular Surgery - Circle or Check any that apply

☐ Blepharoplasty Right Eye	☐ Intravitreal Injections Right Eye	☐ PRK Left Eye	☐ Trabeculectomy Left Eye
☐ Blepharoplasty Left Eye	☐ Intravitreal Injections Left	☐ Ptosis Repair Right Eye	☐ Tube Shunt Right Eye
☐ Cataract Surgery Right Eye	☐ LASIK Right Eye	☐ Ptosis Repair Left Eye	☐ Tube Shunt Left Eye
☐ Cataract Surgery Left Eye	☐ LASIK Left Eye	☐ Punctal Plugs Right Eye	☐ Yag Capsulotomy Right Eye

Initials _____ DOB _____

Allergies & Reactions

☐ Latex Allergy/Reaction ☐ NKDA – No Known Drug Allergy

☐ No Latex Allergy ☐ Other _____

Social History

Current Occupation? _____

How many hours a day do you work on a computer? _____

Do you drive? ☐NO ☐In the Day Time ☐At Night ☐Both

Do you drink alcohol? ☐No ☐Occasional ☐1/day ☐2-3/day ☐4+/day

Do you smoke? ☐No ☐Every Day Smoker ☐Some Day Smoker ☐Former Smoker ☐Never Smoker

Review of Systems - Circle or Check any that apply

☐Poor Vision	☐Loss of Vision	☐Dry Mouth	☐Diarrhea	☐Arthritis	☐Anxiety	☐Allergies
☐Eye Pain	☐Fever	☐High Blood Pressure	☐Constipation	☐Rash	☐Depression	☐Hay Fever
☐Tearing	☐Chills	☐Rapid Heart Beat	☐Burning on Urination	☐Changing Moles	☐Insomnia	☐Hives
☐Redness	☐Weight Loss	☐Congestion	☐Urinary Frequency	☐Headache	☐Diabetes	Other _____
☐Jaw Pain	☐Stuffy Nose	☐Wheezing	☐Incontinence	☐Seizure	☐Thyroid Abnormalities	Other _____
☐Scalp Tenderness	☐Ear Ache	☐Shortness of Breath	☐Joint Pain	☐Stroke	☐Bleeding	Other _____
☐Amaurosis Fugax	☐Cough	☐Upset Stomach	☐Stiffness	☐Paralysis	☐Anemia	Other _____

Alerts - Circle or Check any that apply

☐ Allergy to Adhesive	☐Defibrillator	☐Premedication Prior to Procedures
☐ Allergy to Lidocaine	☐Flomax	☐ Rapid Hear Beat with Epinephrine
☐ Artificial Heart Valve	☐MRSA	☐Pregnancy or Planning a Pregnancy
☐Artificial Joints within Past Two Years	☐ Narrow Angles	☐ Pseudoexfoliation syndrome
☐Blood Thinners	☐ Pacemaker	☐ Steroid responder

Initials _____ DOB _____

☐Corneal Transplant Right Eye	☐LPI Right Eye	☐Punctal Plugs Left Eye	☐Yag Capsulotomy Left Eye
☐Corneal Transplant Left Eye	☐LPI Left Eye	☐Strabismus Surgery	Other _____
☐DSAEK Right Eye	☐LTP Right Eye	☐Retinal Laser Right Eye	Other _____
☐DSAEK Left Eye	☐LTP Left Eye	☐Retina Laser Left Eye	Other _____
☐Eye Muscle Surgery	☐PRK Right Eye	☐Trabeculectomy Right Eye	Other _____

Current Ocular Review - Circle or Check any that apply

☐Visual difficulty Driving	☐Distorted Vision (Halos)	☐Redness	☐Eye Pain or Soreness
☐Problems with Night Vision	☐Glare or light Sensitivity	☐Sandy or gritty feeling	☐Infection of Eye or Lid
☐Eye Injury	☐Loss of Side Vision	☐Itching	☐Tired eyes
☐Loss of Vision	☐Double Vision	☐Burning	☐Amblyopia, Crossed Lazy Eye
☐Blurred Vision	☐Dryness	☐Foreign Body sensation	☐Dropping Eyelid
☐Fluctuating Vision	☐Mucous Discharge	☐Excess tearing or watering	☐Keratoconus or any Corneal Disease

Family History - Circle or Check any that apply

☐ARMD	☐Cataracts	☐Heart Disease	☐Macular Degeneration	☐Stroke
☐Arthritis	☐CVA	☐Hypertension (High Blood Pressure)	☐Migraine	☐Thyroid Disease
☐Blindness	☐Diabetes	☐Kidney Disease	☐Retinal Detachment	Other _____
☐Cancer	☐Glaucoma	☐Lupus	☐Strabismus	Other _____

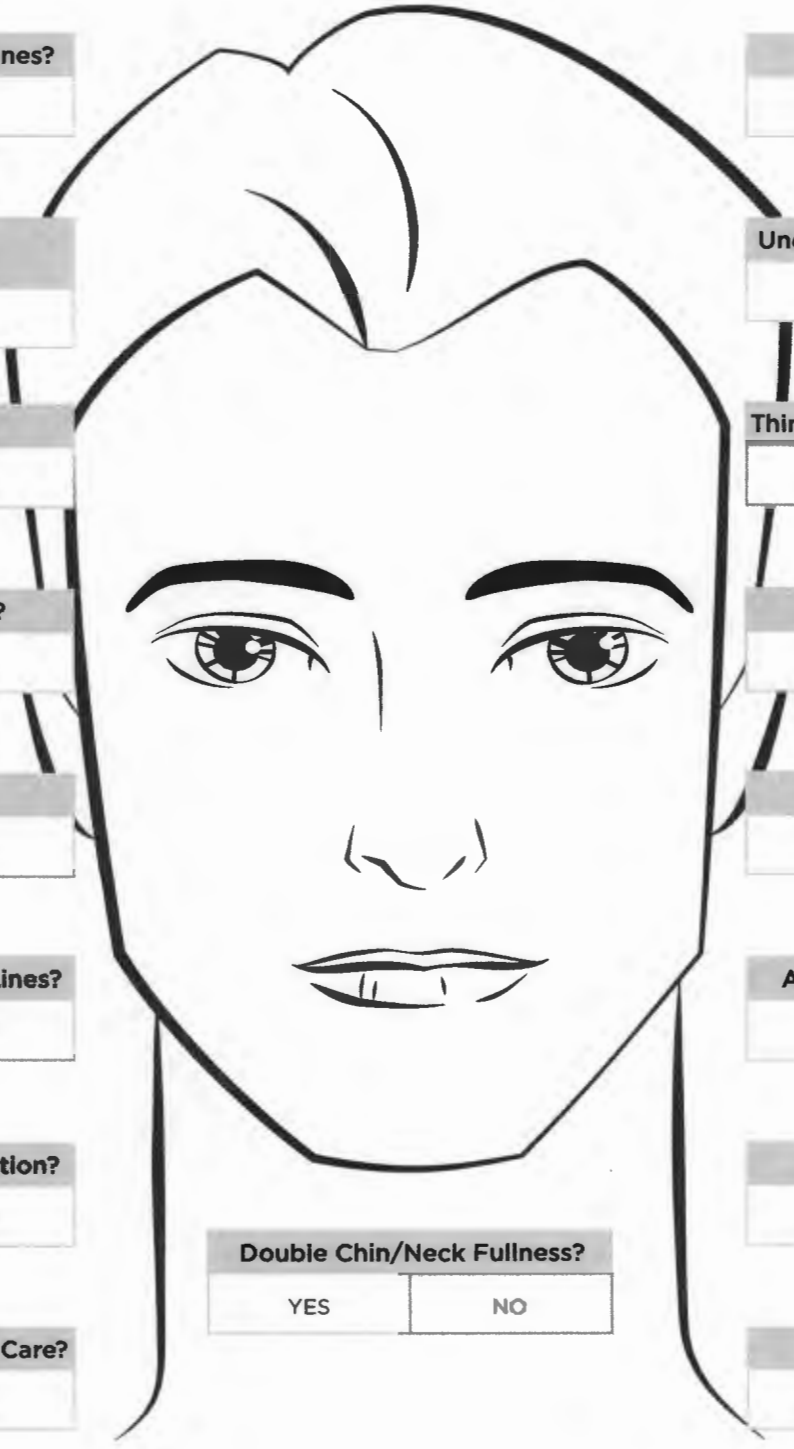
Home Medication List

Home Medication (Include Strength)	Directions (Dose, Route & Frequency)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Initials _____ DOB _____

Patient Concerns

NAME	DATE
EMAIL	PHONE



Forehead Lines/Frown Lines?	
YES	NO

Improve Texture of Skin/Large Pores?	
YES	NO

Facial Volume Loss?	
YES	NO

Nose-to-Mouth Lines?	
YES	NO

Lips/Volume Loss	
YES	NO

Lip Lines/Lipstick Bleed Lines?	
YES	NO

Neck and Chest Discoloration?	
YES	NO

Are You Interested in Skin Care?	
YES	NO

Crow's Feet?	
YES	NO

Under Eye Circles/Lines/Bags?	
YES	NO

Thin, Short or Lightened Lashes?	
YES	NO

Brown Spots/Freckles?	
YES	NO

Broken Blood Vessels?	
YES	NO

Acne Scaring/Facial Scars?	
YES	NO

Red Spots/Flushing?	
YES	NO

Texture/Saggy Skin?	
YES	NO

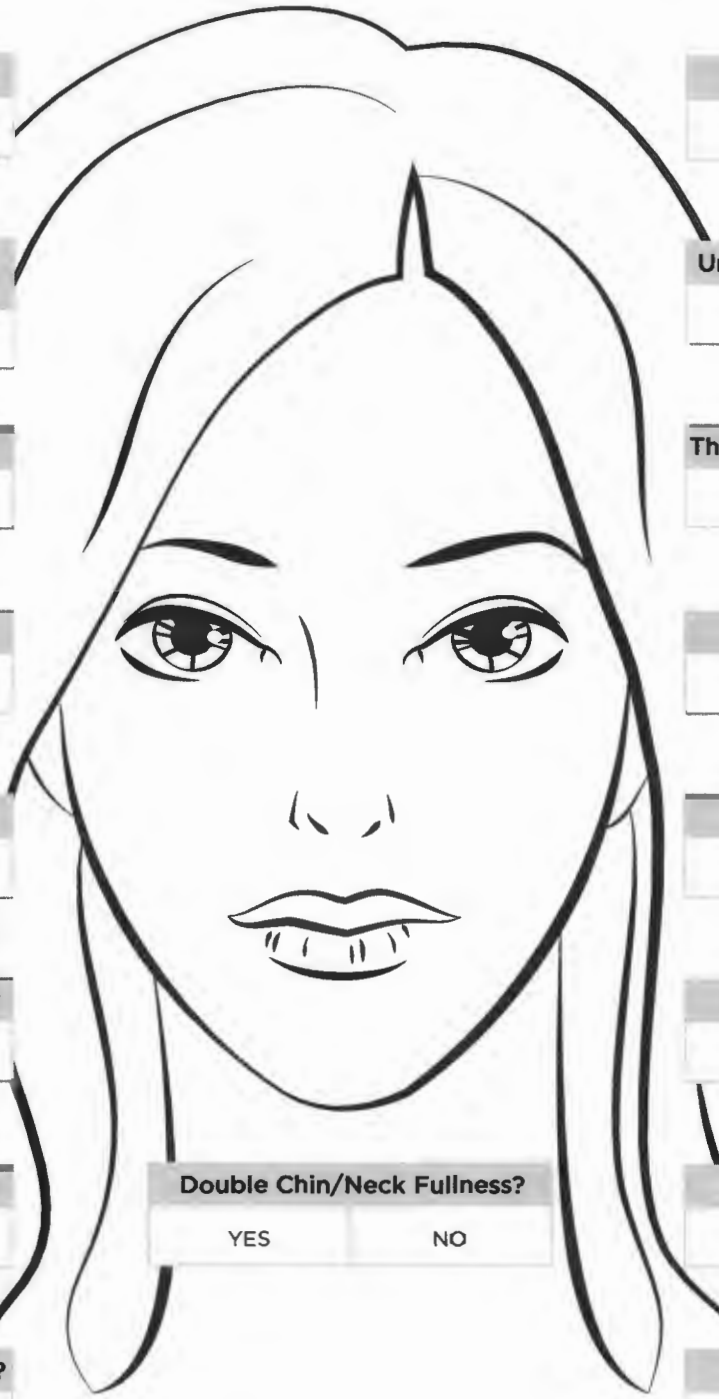
Double Chin/Neck Fullness?	
YES	NO

Please add any additional concerns not listed: _____

Patient Concerns

NAME _____ DATE _____

EMAIL _____ PHONE _____



Forehead Lines/Frown Lines?
YES NO

Improve Texture of Skin/Large Pores?
YES NO

Facial Volume Loss?
YES NO

Nose-to-Mouth Lines?
YES NO

Lips/Volume Loss
YES NO

Lip Lines/Lipstick Bleed Lines?
YES NO

Neck and Chest Discoloration?
YES NO

Are You Interested in Skin Care?
YES NO

Crow's Feet?
YES NO

Under Eye Circles/Lines/Bags?
YES NO

Thin, Short or Lightened Lashes?
YES NO

Brown Spots/Freckles?
YES NO

Broken Blood Vessels?
YES NO

Acne Scaring/Facial Scars?
YES NO

Red Spots/Flushing?
YES NO

Texture/Saggy Skin?
YES NO

Double Chin/Neck Fullness?
YES NO

Please add any additional concerns not listed: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

WYCKOFF OPHTHALMOLOGY

350 Franklin Avenue
Wyckoff, New Jersey 07481

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ('HIPAA"), I have certain rights to privacy regarding my protected 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 that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received; read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment aor health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason:

Advance Beneficiary Notice (ABN) –

NOTE: You need to make a choice about receiving these health care items or services. We Expect that Insurance may not pay for the items(s) or service(s) that are described below. Insurance does not pay for all of your health care costs. Insurance only pays for covered items and services when Insurance rules are met. The fact that Insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Insurance may not pay for some of the following items or services:

Items or Services:

- Contact Lens
- Punctal Plugs
- Refraction
- Routine Examination/ Complete Eye Exam
- Some Surgeries – Premium Implants
- Some Testing – such as OCT, Pentacam, Photographs

Reasons Insurance may not pay

- Deductible
- Not covered
- No Referral

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

Ask us to explain, if you do not understand why Insurance may not pay.
Ask us how much these items or services will cost you (Estimated Cost: $ 15 - 5,000), in case you have to pay for them yourself or through other insurance.

Please Choose ONE Option. Check ONE Box. Then Sign & Date Your Choice.
If you do not select Option 1 or Option 2 then Option 1 will be assumed as your choice.

☐ **Option 1. YES I understand that it will be my responsibility to pay for any items or services that insurance does not pay for.**

I understand that Insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to Insurance. I understand that you may bill me for items or services and that I may have to pay the bill while Insurance is making its decision. If Insurance does pay, you will refund to me any payments I made to you that are due to me. If Insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Insurance's decision.

☐ **Option 2. NO. I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to Insurance and that I will not be able to appeal your opinion that Insurance will not Pay.

Patient's Name	**Signature of patient or person acting on patient's behalf**
Insurance	**Date**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Insurance, your health information on this form may be shared with Insurance. Your health information which Insurance sees will be kept confidential by Insurance.

OMB Approval No. 0938-0566 Form No. CMS –R-131-G (June 2001)

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DESIGNATION OF CERTAIN RELATIVE, FRIENDS, AND/OR OTHER CAREGIVERS

Patient Name: _____

Date of Birth: _____

I agree that Wyckoff Ophthalmology may disclose certain portions of my health information to a relative and/or other caregiver because such person is involved with my health care management or payment relating to my health care. In that instance, Wyckoff Ophthalmology will disclose any information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

_____I wish to make no designation at this time.

Signature of Patient/Parent/Guardian: _____

I designate the following persons listed below as person involved with my healthcare or payment relating to my healthcare for the purpose of Wyckoff Ophthalmology making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name:_____ DOB or Password*:_____

Print Name:_____ DOB or Password*:_____

Print Name:_____ DOB or Password*:_____

**Please list the 4 digit (month & day) date of birth (DOB) of the person listed to choose a password. Please Note: The person will have to give his/her DOB or password in order to receive any information.*

Third Party Portal Access

If I am registered to use the Wyckoff Ophthalmology Patient Portal, I understand and agree that the following persons will be granted third part access to the portal which will allow the individual to view all of my protected health information that is available on the portal.

_____I wish to make no designation at this time.

Print Name: _____ Email Address: _____

Print Name: _____ Email Address: _____

Signature of Patient/Parent/Guardian: _____

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I hereby authorize and guarantee payment for all services rendered.

Although fees for services are due and payment expected at the time services are rendered, if I have been granted a grace period for payment of fees, I acknowledge that payment is due and expected at the time the billing statement is received.

In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge of 1.5% per month on any balance due, as well as a reasonable collection costs not to exceed 50% court costs, attorney fees and interest fees accrued with the collection of this account.

_____

Responsible Party

_____

Date

350 Franklin Avenue ♦ Wyckoff, New Jersey 07481 ♦ Tel: 201-891-0200 ♦ Fax: 201-891-9388