

# WYCKOFF OPTHALMOLOGY

*Disease & Surgery of the Eye*

Melanie Sinatra, M.D., F.A.C.S.

Diplomate of the  
American Board of Ophthalmology

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## Patient Information

Name: \_\_\_\_\_ Marital Status : \_\_\_\_\_

First Middle Last

Address : \_\_\_\_\_ City : \_\_\_\_\_ State : \_\_\_\_\_ Zip : \_\_\_\_\_

DOB : \_\_\_\_\_ SS # : \_\_\_\_\_ Race : \_\_\_\_\_ Ethnicity : \_\_\_\_\_ Language: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Alternate #: \_\_\_\_\_

Email: \_\_\_\_\_ Preferred Contact #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

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## Pharmacy

Pharmacy Name: \_\_\_\_\_ Location: \_\_\_\_\_ Phone #: \_\_\_\_\_

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## Referral Source

Dr. \_\_\_\_\_ Internet: \_\_\_\_\_ Friend: \_\_\_\_\_ Other: \_\_\_\_\_

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## Insurance Information

Primary Insurance: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy or ID# \_\_\_\_\_

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy or ID #: \_\_\_\_\_

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

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## Responsible Party

\_\_\_\_\_ Check if same as patient

Name: \_\_\_\_\_ DOB : \_\_\_\_\_ Relation: \_\_\_\_\_

First Middle Last

SS#: \_\_\_\_\_ Phone #: \_\_\_\_\_ Employer: \_\_\_\_\_ #: \_\_\_\_\_

Address : \_\_\_\_\_ City : \_\_\_\_\_ State : \_\_\_\_\_ Zip : \_\_\_\_\_

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## Medical History – Circle or check any that apply

- Anxiety  Breast Cancer  End State Renal Disease  Hypercholesterolemia (High Cholesterol)  
 Arthritis  Colon Cancer  GERD  Hyperthyroidism  Radiation Treatment  
 Prostate Cancer  Asthma  COPD  Hearing Loss  Hypothyroidism  Seizures  
 Atrial Fibrillation  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 (check):  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
- Contact Lenses     Glasses     Ocular Hypertension Right Eye     Floaters Right Eye
- Corneal Dystrophy Right Eye     Glaucoma Right Eye     Ocular Hypertension Left Eye     Floaters Left Eye
- Corneal Dystrophy Left Eye     Macular Degeneration Right Eye     Ophthalmic Migraine    Other \_\_\_\_\_
- Diabetic Retinopathy, Background Right Eye     Macular Degeneration Left Eye     Pseudoefoliation    Other \_\_\_\_\_
- Diabetic Retinopathy, Background Left Eye     Macular ERM Right 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     LASIK
- Blepharoplasty Left Eye     Intravitreal Injections Left Eye     Ptosis Repair Right Eye     Tube Shunt Right Eye
- Cataract Surgery Right Eye     Trabeculectomy     Ptosis Repair Left Eye     Tube Shunt Left Eye
- Cataract Surgery Left Eye     Yag Capsulotomy Right Eye     Punctual Plugs Right Eye     Punctual Plugs Left Eye
- Corneal Transplant Right Eye     Yag Capsulotomy Left Eye     LPI Right Eye     LTP Right Eye     LTP Left Eye
- Corneal Transplant Left Eye     Strabismus Surgery     LPI Left Eye     Retinal Laser Right Eye
- Eye Muscle Surgery    Other \_\_\_\_\_    Other \_\_\_\_\_     Retinal Laser Left Eye

Initial \_\_\_\_\_

**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 Smoked

**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  Headaches  Diabetes
  - Jaw Pain  Stuffy Nose  Wheezing  Incontinence  Seizure  Thyroid Abnormalities
  - Scalp Tenderness  Ear Ache  Shortness of Breath  Joint Pain  Stroke  Bleeding
  - Amaurosis Fugax  Cough  Upset Stomach  Stiffness  Paralysis  Anemia
  - Other \_\_\_\_\_ Other \_\_\_\_\_ Other \_\_\_\_\_
- 

**Alerts** – Circle or check any that apply

- Allergy to Adhesive  Defibrillator  Premedication Prior to Procedures  Allergy to Lidocaine
  - Flomax  Rapid Heart Beat with Epinephrine  Artificial Heart Valve  MRSA
  - Pregnancy of Planning a Pregnancy  Artificial Joints within Past Two Years  Narrow Angles
  - Pseudoexfoliation Syndrome  Blood Thinners  Pacemaker  Steroid responder
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**Current Ocular Review** – Circle or check any that apply

- Visual difficulty Driving  Distorted Vision (Halos)  Redness  Eye Pain or Soreness  Dryness
  - Problems with Night Vision  Glare or Light Sensitivity  Sandy or Gritty Feeling  Tired Eyes
  - Infection of Eye or Lid  Eye Injury  Loss of Vision  Loss of Side Vision  Excessive tearing or watering
  - Itching  Double Vision  Burning  Amblyopia, Crossed Lazy Eye  Blurred Vision  Dropping Eyelid
  - Foreign Body Sensation  Fluctuating Vision  Mucous Discharge  Keratoconus or any Corneal Disease
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**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  Cancer  Glaucoma  Lupus  Strabismus
- Other \_\_\_\_\_ Other \_\_\_\_\_ Other \_\_\_\_\_

Initial \_\_\_\_\_

**Home Medication List**

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

**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: \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**



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 or 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: \_\_\_\_\_

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**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)

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

**Reasons Insurance may not pay**

- Deductible
- Not covered
- 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 service, 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 and 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 but Insurance.

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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.

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Responsible Party

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Date

# Patient Interest Questionnaire

Please indicate any areas of concern for you

Check all that apply.

Forehead lines



Lip appearance and texture



Frown lines



Thin lips



Crow's feet lines



Double chin



Flattened cheeks/sunken cheeks



Thinning or inadequate lashes



Lines and wrinkles around the nose and mouth



Skin appearance and texture

