WYCKOFF OPHTHALMOLOGY

Disease & Surgery of the Eye

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Diplomate of the
American Board of Ophthalmology

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: _____

Pharmacy

Pharmacy Name: _____ Location: _____ Phone #: _____ Zip:_____

Referral Source

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

Insurance Information

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

Insured Name: _____ DOB:_____ SS#_____

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

Insured Name: _____ DOB:_____ SS#_____

Responsible Party

_____ Check if same as patient

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

SS#: _____ Phone #: _____ Employer:_____ #:_____

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

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 of 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_____

☐ 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 ☐ 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

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

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 chance 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

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 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: _____

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 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
- Avenova® Spray Solution

Reasons Insurance may not pay

- Deductible
- Not covered
- Referral

The purpose of this form is to help you make an informed choice about weather 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.

_____

Responsible Party (Signature)

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That's why it is very important that you keep your scheduled appointment with us, and arrive on time. If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours notice.

If you do not cancel or reschedule your appointment with at least 24 hours notice, we may assess a $50.00 "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it.

_____

Responsible Party (Signature)

_____

Date

Patient Interest Questionnaire

Please indicate any areas of concern for you

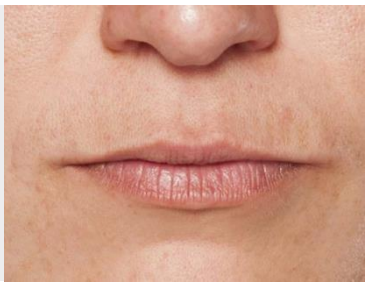
Check all that apply.

☐ 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