

1 Patient's name, address,

Name _____, _____
last name first name Birthdate: _____ Sex: M F

Address _____

 _____, _____ Social Security # _____

Tele (home) _____
 Tele (day) _____
 Tele (cell) _____

Email _____

2 My marital status is:

Single
 Married
 Divorced
 Widow/widower
 Separated
 Other _____

3 My Family Physician (PCP) is: _____
 address _____

 _____, _____
 telephone # _____

4 Please address me as:

Mr Dr
 Mrs Father
 Miss Rev
 Ms Sister
 Other _____

5 My occupation is: _____
 My employer is: _____
 My spouse's name is: _____
 My emergency contact is: _____
 relationship _____
 telephone _____

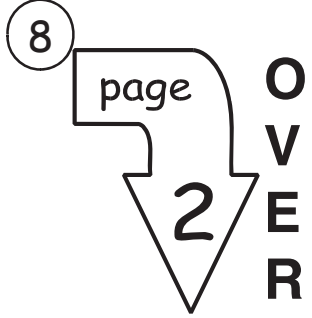
I was referred to
South Jersey
Eye Physicians by: _____

6 Please indicate if this visit is either Workman's Comp or Motor Vehicle Accident related:

Worker's Comp
 Motor Vehicle Accident

7 I authorize release of any medical information concerning today's treatment to my insurance company, attorney or other doctor's office. I also authorize direct payment to South Jersey Eye Physicians, P.A. I understand that, as these services are provided for me or my legal dependent, I am financially responsible for all charges, whether or not paid by insurance.

 (date) (your signature)



Please sign here

Please help us by recording your insurance information here.
Thank you.

INSURANCE #1: Company: _____	ID #: _____
Address---->	PLAN: _____
<i>information is required to file insurance claims</i>	
This insurance is ... (please check one)	<input type="radio"/> ... in your name (you are male) <input type="radio"/> ... in your husband's name <input type="radio"/> ... in your name (you are female) <input type="radio"/> ... in parent's name (boy child) <input type="radio"/> ... in your wife's name <input type="radio"/> ... in parent's name (girl child)
Subscriber information:	The "subscriber" for this policy (i.e. "name of insured") is: _____
	Sex: _____ Birthdate: _____ Soc Security # _____
The subscriber's employer is: _____	<i>information above is for the subscriber</i>

INSURANCE #2: Company: _____	ID #: _____
Address---->	PLAN: _____
<i>information is required to file insurance claims</i>	
This insurance is ... (please check one)	<input type="radio"/> ... in your name (you are male) <input type="radio"/> ... in your husband's name <input type="radio"/> ... in your name (you are female) <input type="radio"/> ... in parent's name (boy child) <input type="radio"/> ... in your wife's name <input type="radio"/> ... in parent's name (girl child)
Subscriber information:	The "subscriber" for this policy (i.e. "name of insured") is: _____
	Sex: _____ Birthdate: _____ Soc Security # _____
The subscriber's employer is: _____	<i>information above is for the subscriber</i>

**Authorization to Disclose
Medical Information**

Patient Name: _____ Chart#: _____

Birthdate: _____ Date: _____

Address: _____

Permission to Disclose Medical Information *(Must be completed by a parent/guardian if the patient is under the age of 18)*

I give permission for South Jersey Eye Physicians, PA to discuss medical information for the above named patient, including examinations and test results with the following friends or family members. If left blank, information will only be given directly to the patient (or parent/guardian if under age 18).

Name Relationship

Name Relationship

Name Relationship

Name Relationship

This authorization will remain in effect at South Jersey Eye Physicians, PA until it is either revoked or changed.

This document is authorized and signed by self (patient) parent guardian

Signature

Printed Name

Please answer these questions about your medical history:

Patient Name _____ Chart # _____ Date: _____

In order to take best care of your eyes, it is very important for us to understand your overall medical history and current condition. Please help us by fully and accurately answering the following questions while you wait to be called back to the clinic. If you don't know how to answer some of these questions, please do as much as you can, and ask the Technician for help on the rest after he/she begins your examination.

Please fill out all 3 sheets.

Please check "yes" or "no" for each question.

Your personal medical history. Do you have any of the following?

<u>Yes</u>	<u>No</u>	<u>Question</u>	<u>Explain</u>
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (when was it diagnosed?)	
<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	
<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems	
<input type="checkbox"/>	<input type="checkbox"/>	Stomach/intestinal problems	
<input type="checkbox"/>	<input type="checkbox"/>	Genital/Urinary Problems	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	
<input type="checkbox"/>	<input type="checkbox"/>	Migraines	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke, neurological disease	
<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	
<input type="checkbox"/>	<input type="checkbox"/>	Other Problems	

Your Personal Eye History: Do you have any of the following EYE problems?

<u>Yes</u>	<u>No</u>	<u>Question</u>	<u>Explain</u>
<input type="checkbox"/>	<input type="checkbox"/>	Macular degeneration	
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	
<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	
<input type="checkbox"/>	<input type="checkbox"/>	Eye Injury	
<input type="checkbox"/>	<input type="checkbox"/>	Surgery (what, when, which eye?)	

Your Family Medical History: To your knowledge, have any of your grandparents, parents, aunt or uncles, brothers or sisters ever had any of the following problems?

<u>Yes</u>	<u>No</u>	<u>Question</u>	<u>Explain</u>
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	
<input type="checkbox"/>	<input type="checkbox"/>	Other Ocular Problems	

... please continue with Page 2

Your Social History: Do you?

<u>Yes</u>	<u>No</u>	<u>Question</u>	<u>Comments</u>
<input type="checkbox"/>	<input type="checkbox"/>	Use Tobacco	
<input type="checkbox"/>	<input type="checkbox"/>	Drink Alcohol	
<input type="checkbox"/>	<input type="checkbox"/>	Drive	
<input type="checkbox"/>	<input type="checkbox"/>	Live Alone	
What is your occupation (job)?			

Your PCP (primary care physician) or pediatrician: _____

Please provide: City _____
Telephone _____

drops, ointments & pills for the EYE

Medications you take for your eyes (Include over-the-counter drugs and vitamins/nutritional supplements):

Medication	Strength	Right Eye	Left Eye	Both Eyes	How often
_____	_____	R	L	Both	_____ times per day
_____	_____	R	L	Both	_____ times per day
_____	_____	R	L	Both	_____ times per day
_____	_____	R	L	Both	_____ times per day
_____	_____	by mouth			_____ times per day
_____	_____	by mouth			_____ times per day

medicines NOT for the EYE

Medications that you take for other problems (Include over-the-counter drugs and vitamins/nutritional supplements):

Medication	Strength	
_____	_____ dose	_____ times per day
_____	_____ dose	_____ times per day
_____	_____ dose	_____ times per day
_____	_____ dose	_____ times per day
_____	_____ dose	_____ times per day
_____	_____ dose	_____ times per day
_____	_____ dose	_____ times per day

Please list all medication allergies:

... please continue with Page 3

Please answer these questions about any symptoms / problems you may be experiencing:

	<u>Yes</u>	<u>No</u>	<u>Question</u>	<u>Explanation</u>
(const)	<input type="checkbox"/>	<input type="checkbox"/>	Have you gained/lost weight recently?	
	<input type="checkbox"/>	<input type="checkbox"/>	Do you feel tired all of the time?	
	<input type="checkbox"/>	<input type="checkbox"/>	Do you have headaches?	
(heent)	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a persistent sore throat, sinus problems?	
	<input type="checkbox"/>	<input type="checkbox"/>	Do you have persistent earaches or hearing loss?	
(gi)	<input type="checkbox"/>	<input type="checkbox"/>	Do you have nausea, vomiting, abdominal pain or diarrhea?	
(gu)	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any problems with urination, blood in your urine, or kidney problems?	
(cv)	<input type="checkbox"/>	<input type="checkbox"/>	Do you have chest pains or irregular heartbeat?	
(derm)	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any skin problems –rashes, eczema, psoriasis, excessive dryness, etc?	
(resp)	<input type="checkbox"/>	<input type="checkbox"/>	Do you have problems with your lungs, chronic cough, difficulty breathing or wheezing?	
(ms)	<input type="checkbox"/>	<input type="checkbox"/>	Do you have problems with your bones, muscles or joints?	
(neuro)	<input type="checkbox"/>	<input type="checkbox"/>	Do you have convulsions or seizures?	
	<input type="checkbox"/>	<input type="checkbox"/>	Do you have confusion, numbness, weakness or paralysis?	

Please sign here. Thank you.

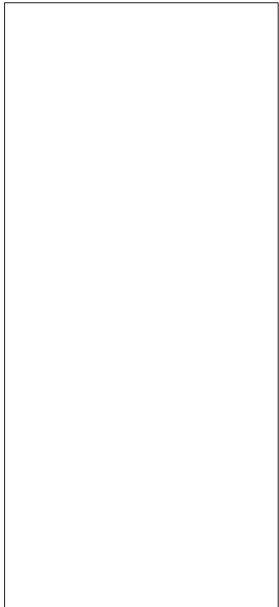
The above information is true and correct to the best of my belief.

(patient's signature)

(date)

(please sign here if parent or legal guardian)

(doc init) _____
(date)



... please sign above