MEDICAL REGISTRATION FORM

Today's Date:	***Have you been seen at this office before?*** ☐ Yes ☐No

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Ms. ☐ Dr.	***If minor, Parent or Guardian Name:***

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Social Security No:	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Apt.:	City:	State:	Zip Code:

Cell phone no:	Work phone no:	Home phone no:	Email:
Occupation:	Employer:	Employer phone no.:	Student: Full Time☐ Part-Time☐
Marital Status: Single ☐ Married☐ Divorced☐ Widowed ☐		Last Eye Exam:	

Last Medical Exam:	Primary Care Physician:	PCP phone no:

INSURANCE INFORMATION

(Fill out all insurance information including primary subscriber's name and DOB.)

Primary Insurance:	ID#:	Group#:
Secondary Insurance:	ID#:	Group#:

Subscriber's Full Name:	Subscriber' DOB:

Patient's Relationship to Subscriber:	☐ Self ☐ Spouse ☐ Child ☐ Other	Same Address? ☐ Yes ☐ No

MEDICAL HISTORY

Check if you have had any of the following conditions: ☐ crossed eyes ☐ lazy eye ☐ drooping eye lid ☐ prominent eyes

☐ glaucoma ☐ retinal disease ☐ cataract ☐ eye infections ☐ eye injury ☐ other ocular condition _____

Do you have any allergies to medications? ☐ Yes ☐ No If yes, explain: _____

_____

List any medications you take (including over the counter medications and home remedies): _____

_____

☐ Aspirin Regularly ☐ Hi Doses Vitamins ☐ Antihistamines ☐ Oral Contraceptives

List all major injuries, surgeries and/or hospitalizations you have had: _____

Are you pregnant or nursing?	☐ Yes ☐ No
Do you wear glasses?	☐ Yes ☐ No If yes, how old is your current pair of glasses? _____
Do you wear contact lenses?	☐ Yes ☐ No If yes, type of contact lenses worn: ☐ Disposable ☐ Rigid GP ☐ Astigmatic ☐ Multifocal

FAMILY HISTORY

Please note any family history (parent, grandparent, sibling, children, living or deceased) for the following conditions:

Blindness	☐ Yes ☐ No Who?_____	Diabetes	☐ Yes ☐ No Who?_____
Cataract	☐ Yes ☐ No Who?_____	Heart Disease	☐ Yes ☐ No Who?_____
Crossed Eyes	☐ Yes ☐ No Who?_____	High Blood Pressure	☐ Yes ☐ No Who?_____
Glaucoma	☐ Yes ☐ No Who?_____	Kidney Disease	☐ Yes ☐ No Who?_____
Macular Degeneration	☐ Yes ☐ No Who?_____	Lupus	☐ Yes ☐ No Who?_____
Retinal Detachment/Disease	☐ Yes ☐ No Who?_____	Thyroid Disease	☐ Yes ☐ No Who?_____
Arthritis	☐ Yes ☐ No Who?_____	Other	☐ Yes ☐ No Who?_____
Cancer	☐ Yes ☐ No Who?_____		

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ **Yes, I would prefer to discuss my social history information directly with my doctor. (check box)**

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No If yes, please describe:

Do you use tobacco products?	☐ Yes ☐ No If yes, type/ amount/ how long: _____
Do you drink alcohol?	☐ Yes ☐ No If yes, type/ amount/ how long: _____
Do you use illegal drugs?	☐ Yes ☐ No If yes, type/ amount/ how long: _____

Have you ever been exposed to or infected with: ☐ Herpes ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ Gonorrhea

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas: CHECK YES OR NO.

EYES		**EAR, NOSE, MOUTH THROAT**	
Loss Of Vision	☐ Yes ☐ No	Allergies/ Hay Fever	☐ Yes ☐ No
Blurred Vision	☐ Yes ☐ No	Sinus Congestion	☐ Yes ☐ No
Distorted Vision/ Halos	☐ Yes ☐ No	Runny Nose	☐ Yes ☐ No
Loss of Side Vision	☐ Yes ☐ No	Post-Nasal Drip	☐ Yes ☐ No
Double Vision	☐ Yes ☐ No	Chronic Cough	☐ Yes ☐ No
Dryness	☐ Yes ☐ No	Dry Throat/ Mouth	☐ Yes ☐ No
Mucous Discharge	☐ Yes ☐ No	**RESPIRATORY**	
Redness	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Sandy or Gritty Feeling	☐ Yes ☐ No	Chronic Bronchitis	☐ Yes ☐ No
Itching	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No
Burning	☐ Yes ☐ No	**VASCULAR/ CARDIOVASCULAR**	
Foreign Body Sensation	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Excess Tearing/ Watering	☐ Yes ☐ No	Heart Pain	☐ Yes ☐ No
Glare/ Light Sensitivity	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Eye Pain/ Soreness	☐ Yes ☐ No	Vascular Disease	☐ Yes ☐ No
Chronic Infection of Eye or lid	☐ Yes ☐ No	**GASTROINTESTINAL**	
Styes or Chalazion	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No
Flashes of Light	☐ Yes ☐ No	Constipation	☐ Yes ☐ No
Floaters in Vision	☐ Yes ☐ No	**GENITOURINARY**	
Tired eyes	☐ Yes ☐ No	Genitals/ Kidney/ Bladder	☐ Yes ☐ No _____
SYSTEM CONSTITUTIONAL		**BONES/ JOINTS/ MUSCLES**	
Fever, weight loss/ gain	☐ Yes ☐ No _____	Rheumatoid Arthritis	☐ Yes ☐ No
INTEGUMENTARY (skin)	☐ Yes ☐ No _____	Muscle Pain	☐ Yes ☐ No
NEUROLOGICAL		Joint Pain	☐ Yes ☐ No
Headache	☐ Yes ☐ No	**LYMPHATIC/ HEMATOLOGIC**	
Migraines	☐ Yes ☐ No	Anemia	☐ Yes ☐ No
Seizures	☐ Yes ☐ No	Bleeding Problems	☐ Yes ☐ No
ENDOCRINE		**ALLERGIC/ IMMUNOLOGIC**	☐ Yes ☐ No _____
Thyroid/ Other/ Glands	☐ Yes ☐ No _____	**PSYCHIATRIC**	☐ Yes ☐ No _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Hillsdale Vision Center, P.C./Adam Gardner O.D. all medical payments and benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the release of information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

Hillsdale Vision Center
185 Broadway
Hillsdale, NJ 07642
(201) 666-0230

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We will abide by the terms of this notice while it is in effect. This notice takes effect April 14, 2003 and will remain in effect until we replace or change it. We reserve the right to change this notice at any time as allowed by law. If we change it, the new privacy practices will apply to your current health information as well as any future information that may be generated. We will post the new Notice and have copies of it available in our office.

TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or healthcare operations. **Example of treatment purposes are**: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; referring you to another doctor or clinic for eye care services; or getting copies of you health information from another professional that you may have seen before us**. Examples of payment purposes are**: filing claims for reimbursement from health or vision care plans, or other sources of payment; and collecting unpaid balances. "Healthcare operations" means those administrative and managerial functions that we have to do in order to run our office. **Examples of healthcare operations are**: internal quality assurance; participation in managed care plans; and patient recall notices.

USES AND DISCLOSURES FOR OTHER REASONS

The law also allows or requires us to use or disclose you health information without a specific authorization for other reasons. Not all these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are;

- When a state or federal law mandates that certain health information be reported for a specific purpose, including public health purposes, judicial and administrative proceedings, and reports to and from the FDA regarding drugs and medical devices.
- To appropriate authorities about victims of suspected abuse, neglected or domestic violence.
- For health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of healthcare laws.
- For law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else.
- For purposed of worker's compensation programs.
- Incidental disclosures that are an unavoidable by product of permitted uses or disclosures.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a specific "authorization form". Details of any other disclosures will be specified in the authorization form. Initiation of a disclosure, whether by you or by us, requires that we ask you to sign an authorization form. You do not have to sign it but if you do not, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing and sent to the office contact person named at the beginning of the notice.

(continued)

HIV RELATED INFORMATION AND INFORMATION CONCERNING ALCOHOL AND SUBSTANCE ABUSE SERVICES

New Jersey State law includes special protection for HIV-related information. We will not disclose information concerning your HIV status or HIV testing without obtaining a specific written authorization, except under certain circumstances in which such a disclosure is authorized or required by law or in cases of emergency.

Health information possessed by federally supported alcohol and substance abuse treatment programs are also subject to special protection under federal law. If we receive information about you from on of these programs, we will not re-disclose it without your specific written authorization, except under circumstances in which such a disclosure is authorized by law or in cases of emergency.

PATIENT RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us for additional restrictions on the use and disclosure of your health information. We do not have to agree to these restrictions, but if we do, we will honor your request.
- Ask us to communicate with you in an alternative way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by sending an e-mail to your personal e-mail address. We will accommodate these requests if they are reasonable.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse. You are also specifically entitled to obtain copies of your eyeglass or contact lens prescription upon your request. We may ask that you pay for the costs of the copies.
- Ask us to amend you health information.
- Get a list of the disclosures that we have made of your health information for the past 6 years but not prior to April 14, 2003. The list will not include: disclosures for purposes of treatment, payment or healthcare operations; disclosures with you authorization, incidental disclosures, or disclosures required by law. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance.
- Get additional paper copies of this Notice of Privacy Practices upon request.

If you wish to exercise any of your rights listed above you may do so in writing to the contact person whose name appears at the beginning of this privacy notice.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information you are free to complain to us or the U.S. Department of Health and Human Services. If you want to complain to us, send a written complaint to the office contact person at the address shown at the beginning of this Notice.

NOTICE OF PRIVACY PRACTICES

I have read and understand the Hillsdale Vision Center, P.C. Notice of Privacy Practices, which states the reasons for disclosure of my health information for the purpose of treatment, payment and healthcare operations.

Patient Signature (or parent's signature): _____ Date: _____

Print Name: _____

If you wish to have any of your medical information released to a family member, please fill out information below. I authorize this office to speak with the below listed individual regarding my appointment times, rescheduling of appointment times, to go over insurance benefits, and/or the results of tests and procedures.

Individual's Name _____ Relation to Patient _____

OFFICE USE ONLY: REFUSED TO SIGN _____ TECH'S INITIALS _____ DATE _____

NOTIFICATION OF SERVICES NOT COVERED BY MEDICAL INSURANCE

REFRACTION SERVICE AND FEE

A refraction is the process of determining if there is a need for corrective lenses. It is an essential part of an eye examination and necessary to write a prescription. This is not considered a medical procedure.

Most medical insurance plans, including Medicare, do NOT cover routine refractions. Since it is not a covered service, Medicare allows that we charge separately for that portion of the examination.

Our office fee for refraction is $20 and this fee will be collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

Patient Acknowledgement

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the refraction fee, and understand that payment is due at the time of service. Any co-payment, coinsurance, or deductibles I may have, are separate from and not included in the refraction fees.

_____ _____

Patient Signature (Parent for Minor) **Date**

_____

Print Name of Patient