Affiliated Eye Surgeons of Northern NJ, pa

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Mr Mrs Miss Ms ____**Date:** _______________

Phone: Home ( )____________ **Cell ( )**_____________ **Work ( )**________________

Home Address ____

City ____**State** ________ **Zip** _____________

Email Address ____

Pharmacy ______________________**City**_________________ **Phone** ________________

Sex: M F Marital Status: Single Divorced Married Widowed Separated

Social Security #: _______________________________ **Date of Birth** ____/____/____

Referred by _____________________________________ **Phone** ___________________

Family Physician _______________________________ **Phone** ___________________

Your Occupation ____

Your Employer __________________________________ **Phone** ___________________

Employer's Address ____

City ____**State** ________ **Zip** _____________

Spouse's Name ____

I request that payments from insurance companies in which my doctor participates be made directly to Affiliated Eye Surgeons. I consent that medical information about me may be used or released for the purpose of treatment, payment or healthcare operations to appropriate agencies or to facilitate my claims without my prior written consent or authorization. I understand that while this office may submit the insurance claim on my behalf, the ultimate responsibility for payment of services rendered is mine. I understand further that submission of claims to secondary insurance carriers may be my responsibility if not performed automatically by my primary insurance carrier.

Signed ____ **Date** ___________

MEDICAL Insurance — (Primary)

Insurance Name ______________________________ ID # ________________

Address ____________________________________ Group # ________________

ARE MEDICAL REFERRALS NEEDED? YES NO Copay $ ________________

Subscriber's Name ____

Subscriber's Date of Birth ______________________

Subscriber's Social Security # ____________________

MEDICAL Insurance — (Secondary)

Insurance Name ______________________________ ID # ________________

Address ____________________________________ Group # ________________

ARE MEDICAL REFERRALS NEEDED? YES NO Copay $ ________________

Subscriber's Name ____

Subscriber's Date of Birth ______________________

Subscriber's Social Security # ____________________

VISION / EYE Insurance (If available)

Insurance Name ______________________________ ID # ________________

Address ____________________________________ Group # ________________

ARE MEDICAL REFERRALS NEEDED? YES NO Copay $ ________________

Subscriber's Name ____

Subscriber's Date of Birth ______________________

Subscriber's Social Security # ____________________

Name ______________________ Birthdate__________ Date _________

	YES	NO		
Do you wear Glasses for vision?	_____	_____	Last changed when?	____________
Do you wear Contacts for vision?	_____	_____	Last changed when?	____________
Do you have Glaucoma?	_____	_____	How many years?	____________
Do you have Cataracts?	_____	_____	How many years?	____________
Have you ever had an EYE INJURY?	_____	_____	Explain?	____________
Have you ever had EYE SURGERY?	_____	_____	For What?	____________

If YES, which EYE? RIGHT _________ Date of surgery ____________ Surgeon?____________

LEFT _________ Date of surgery ____________ Surgeon?____________

DO YOU SUFFER FROM ANY OF THE FOLLOWING?

	YES	NO	# YRS		YES	NO	# YRS
High Blood Pressure?	____	____	_____	Auto-Immune Disease?	____	____	_____
Diabetes?	____	____	_____	Lung Disease?	____	____	_____
Bleeding Disorder?	____	____	_____	Cardiac Disorder?	____	____	_____
Skin Cancer?	____	____	_____	Urinary Problems?	____	____	_____
Stroke?	____	____	_____	Stomach/GI Problems?	____	____	_____
Fever or Chills?	____	____	_____	Mental Illness?	____	____	_____
Headaches?	____	____	_____	Thyroid Problems?	____	____	_____
Do you smoke?	____	____	_____	Do you drink alcohol?	____	____	_____

Other medical conditions , if yes to anything above, describe? ______________________________

Allergies to medication? __ Y / N_____NAME:____________________Type of reaction? ______________

List ALL Medication—Including Eye Drops and Aspirin

Medication	Dosage/Day	Medication	Dosage/Day
______________________	_________	______________________	_________
______________________	_________	______________________	_________
______________________	_________	______________________	_________
______________________	_________	______________________	_________

Is there any FAMILY HISTORY of:

	YES	NO	Which Relative(s)
Cataracts?	_______	_______	______________________________
Glaucoma?	_______	_______	______________________________
Diabetes?	_______	_______	______________________________
Retinal Disease?	_______	_______	______________________________
Loss of Vision?	_______	_______	______________________________