Affiliated Eye Surgeons of Northern NJ, pa

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Mr Mrs Miss Ms _____Date_____

Phone: Home ( )_____ Work ( )_____ Cell ( )_____

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 _____

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)

Company Name _____ Policy # _____

Address _____ Group # _____

ARE MEDICAL REFERRALS NEEDED? YES NO Copay $ _____

Subscriber's Name _____

Subscriber's Date of Birth _____

Subscriber's Social Security # _____

MEDICAL Insurance — (Secondary)

Company Name _____ Policy # _____

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)

Company Name _____ Policy # _____

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
Hypertension?	____	____	_____	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? _____

Allergies to medication? _____**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?	_____	_____	_____