Red Bank Eye

41 East Front Street, Red Bank, NJ 07701
Phone: 732-741-0170 • Fax: 732-741-2808
redbankeye.com

Patient Questionnaire *Please print clearly*

Today's Date _____

Name (First) _____ (Last) _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Gender ❑ Male ❑ Female Date of Birth _____

Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated Spouse Name _____

Language preference ❑ English ❑ Spanish ❑ Other: _____ Ethnicity *(Italian, Polish, etc.)* _____

Race ❑ Caucasian ❑ African American ❑ Hispanic ❑ Asian ❑ Middle-Eastern ❑ Pacific Islander ❑ Native American

Home Phone# _____ Work/Cell Phone# *(please circle one)* _____

Email Address _____ Contact Preference *(email, cell, text etc.)* _____

How were you referred to our office? _____

Your Occupation _____ Employer _____

Address _____ City _____ State _____ Zip _____

Person who holds primary health *(or vision)* insurance:

Name _____ Date of Birth _____

Insurance Carrier _____ ID Number _____

Person who holds secondary health *(or vision)* insurance:

Name _____ Date of Birth _____

Insurance Carrier _____ ID Number _____

Primary Care Provider: Do you have a primary care physician? ❑ Yes ❑ No

Doctor's name _____ Office Address _____

Phone # _____ Fax # _____

PHYSICAL MEDICINE **Do you have a pacemaker?** ❑ Y ❑ N **Are you pregnant?** ❑ Y ❑ N **Are you nursing?** ❑ Y ❑ N

MEDICATIONS

Date Started	Medication	Dosage

ALLERGIES TO MEDICATIONS

Medication	Reaction

Name: _____ Date: _____

PRIOR EYE-RELATED INJURIES OR SURGERY

Date	Reason
_____	_____
_____	_____

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING CONDITIONS?

Constitutional Symptoms
- ❑ Fever
- ❑ Weight Loss
- ❑ Chills
- ❑ Fatigue
- ❑ Weakness
- ❑ Other _____

Eyes
- ❑ Blurred Vision
- ❑ Burning
- ❑ Tearing
- ❑ Gritty/Sandy Feeling
- ❑ Itching
- ❑ Dryness
- ❑ Eye Pain
- ❑ Poor Color Vision
- ❑ Other _____

Ears/Nose/Mouth
- ❑ Poor Hearing
- ❑ Hearing Aid
- ❑ Sinus Problems
- ❑ Sjogren's syndrome
- ❑ Dry Mouth
- ❑ Other _____

Cardiovascular
- ❑ High Blood Pressure
- ❑ Poor Circulation
- ❑ High Cholesterol
- ❑ Heart Flutter
- ❑ Pacemaker
- ❑ Heart Symptoms
- ❑ Edema (Swelling)
- ❑ Other _____

Respiratory
- ❑ Shortness of Breath
- ❑ Asthma
- ❑ Emphysema
- ❑ Tuberculosis
- ❑ Lung Cancer
- ❑ Other _____

Gastrointestinal
- ❑ Upset Stomach
- ❑ Ulcer(s)
- ❑ Esophageal Reflux
- ❑ Gastritis
- ❑ Ulcerative Colitis
- ❑ Diarrhea
- ❑ Other _____

Genitourinary
- ❑ Burning with Urination
- ❑ Frequency of Urination
- ❑ Enlarged Prostate
- ❑ Prostate Cancer
- ❑ Other _____

Musculoskeletal
- ❑ Arthritis
- ❑ Muscle Pains or Aches
- ❑ Muscle Weakness
- ❑ Back Pain
- ❑ Other _____

Skin
- ❑ Rash
- ❑ Eczema
- ❑ Psoriasis
- ❑ Hair Loss
- ❑ Dry/Itchy Skin or Scalp
- ❑ Rosacea
- ❑ Other _____

Neurological
- ❑ Headaches
- ❑ Migraines
- ❑ Seizure Disorder
- ❑ Dizziness
- ❑ Fainting Spells
- ❑ Weakness on One Side
- ❑ Stroke
- ❑ Multiple Sclerosis
- ❑ Transient Ischemic Attack
- ❑ Peripheral Neuropathy
- ❑ Other _____

Psychiatric
- ❑ Depression
- ❑ Anxiety
- ❑ Hospitalization for Mental Health
- ❑ Bipolar Disorder
- ❑ Schizophrenia
- ❑ Other _____

Endocrine
- ❑ Thyroid
- ❑ Juvenile Diabetes
- ❑ Diabetes Type I
- ❑ Diabetes Type II
- ❑ Excessive Weight Gain/Loss
- ❑ Excessive Thirst or Urination
- ❑ Get up frequently at night to urinate
- ❑ Other _____

Hematology/Lymphatic
- ❑ Blood Disorder
- ❑ Excessive Bleeding
- ❑ Blood Clotting Problem
- ❑ Bruise Easily
- ❑ Other _____

Allergy/ Immunology
- ❑ Seasonal Allergies
- ❑ Other Allergies
- ❑ Autoimmune Disease
- ❑ Sarcoidosis
- ❑ Immunologic Problems
- ❑ Lupus
- ❑ Scleroderma
- ❑ Rheumatoid Arthritis
- ❑ Shingles
- ❑ Other _____

Name: _____ Date: _____

SURGERIES & DATE

❑ Cataract _____
❑ Lasik _____
❑ Appendectomy _____
❑ Hysterectomy _____
❑ Gall Bladder _____
❑ Hernia _____
❑ Tonsillectomy _____
❑ Dental Surgery _____
❑ Joint Replacement Knee/Hip _____
❑ Heart Surgery – Bypass Valve _____
❑ Angioplasty or Stent _____
❑ Pacemaker _____
❑ Other _____
_____

FAMILY MEDICAL HISTORY

❑ Cataracts ❑ Glaucoma ❑ Macular Degeneration
❑ Diabetes ❑ Heart Disease ❑ Seizure ❑ Eye Turn
❑ Retinal Detachment ❑ High Blood Pressure
❑ Other _____
Your Height: _____ft. _____inches
Weight: _____lbs.

Do you smoke? ❑ Yes ❑ No
Have you quit within the past 24 months (2 years)? ❑ Yes ❑ No
Have you ever smoked? ❑ Yes ❑ No
Do you drink? ❑ Yes ❑ No
If yes, how much & how often? _____
❑ Previously ❑ None

Do you have any vision related concerns? _____
_____

VISION LIFESTYLE

Which of the following visual demands do you encounter on a regular basis?
❑ Reading Small Print ❑ Computer Work
❑ Classroom/ Board Work ❑ Outdoors ❑ Natural Lighting
❑ Artificial Lighting ❑ Fine/ Close-up Work
❑ Potential Eye Hazards ❑ Other _____
How much time do you spend on the computer daily?
❑ None ❑ 1-2 hours ❑ 3-6 hours ❑ More

How many pairs of prescription eyeglasses do you currently use? _____
What do you currently like OR dislike about your current eyeglasses? (weight, thickness, style, etc.)t
_____
_____
Do you have prescription sunglasses? ❑ Yes ❑ No

Which of the following hobbies or activities do you participate in?
❑ Art/Painting/Drawing ❑ Woodworking/Carpentry ❑ Fishing
❑ Swimming ❑ Baseball/ Softball ❑ Sewing/Crafts ❑ Golf
❑ Tennis ❑ Biking ❑ Hunting/Shooting ❑ Pilot ❑ Travel
❑ Boating/ Water sports ❑ Jogging/Running ❑ Racquetball
❑ Watching TV ❑ Driving ❑ Musical Instrument ❑ Reading
❑ Welding ❑ Exercise ❑ Skiing/Snowboarding ❑ Soccer
❑ Other _____

Are you bothered by bright light, reflections, or glare? ❑ Yes ❑ No
Do you have difficulty when driving at night? ❑ Yes ❑ No
Do you wear contact lenses? ❑ Yes ❑ No
What do you currently like OR dislike about your current contact lenses? (vision, comfort, color etc.)
_____
_____

RETINAL CAMERA OR DILATION

A new highly sophisticated, computerized assisted digital camera in our office enables us to provide a very detailed retinal analysis of your eyes. **Retinal photography** can document and record problems associated with Diabetes, High Blood Pressure, Cancer, Cataracts, Glaucoma, Macular Degeneration, etc.

Typically, our doctors will dilate your pupils with eye drops to analyze your eyes for these concerns. For many patients, Retinal Photos **will take the place** of the Dilation, and you will not leave our office with uncomfortable, blurry vision or light sensitivity.

If our doctor finds something of medical significance in your eyes while taking these photos, we will bill your medical insurance for this service. If there are no medical findings, you will be charged **$40**. These images will remain in your electronic chart for years to come, and will serve as a baseline as you age. The doctors in our office highly recommend Retinal Photos!

Please indicate which you would prefer to have done today *(Choose one)* :

❑ **Retinal Photography *($40 if there are no medical findings today)***
❑ **Dilation *(no additional charge)***

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HIPAA Notice of Privacy Practices

HIPAA (the Health Insurance Portability & Accountability Act of 1996) was passed to provide rules for how medical care providers might use your Protected Health Information (PHI). It also provides you with certain rights pertaining to that information. As a provider of healthcare services, Red Bank Eye fully complies with all HIPAA regulations. These regulations require that we provide you with the HIPAA Notice of Privacy Practices, which is reproduced below.

Please sign below to acknowledge receipt of this information, and return this form to us at the time of your first visit. Thank you.

I have received the HIPAA Notice of Privacy Practices information from Red Bank Eye.

Print Name: _____

Signature: _____ Date: _____

This notice describes how medical information about you may be used and disclosed as per HIPAA regulations, and describes your rights regarding access to this information. Please review it carefully.
This Notice of Privacy Practices describes how Red Bank Eye may use and disclose your Protected Health Information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 of HIPAA.

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Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

1. **You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

2. **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

3. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**

4. **You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e., electronically.)**

5. **You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

6. **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections please ask to speak with our HIPAA Compliance Officer in person or by phone at 732-741-0170.

I have received the HIPAA Notice of Privacy Practices information from Red Bank Eye.

Print Name: _____

Signature: _____ Date: _____

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General Informed Consent

Name: _____ Date: _____

Most insurance plans cover services that they consider medically necessary and/or reasonable and customary. Some of our services such as refractions, retinal fundus photos and/or contact lens exams are often not considered by insurance companies to be necessary or a "covered service" and, therefore, reimbursable, based upon their own criteria. Our office does not accept insurance assignment for out-of-network plans. By signing this form you accept full financial responsibility for all non-covered services; including, but not limited to, consultations, refractions, retinal fundus photography, corneal and contact lens evaluations, binocular vision evaluations, perceptual evaluations, and vision therapy. Your signature is being given prior to rendering any services, advice, and/or recommendations whatsoever from Red Bank Eye. It is the responsibility of the patient to follow-up with our office for results of all testing and laboratory procedures. It should not be assumed on the part of the patient if they are not contacted by Red Bank Eye, or its employees, or if the patient does not schedule or keep consultation, that test results are normal (or without abnormalities), and may not require further follow-up or advice. Health/vision recommendations and/or possible referral and additional follow-up may be warranted based upon laboratory and evaluations. The patient is further notified that some tests, or all, may not be covered by their insurance company. The patient assumes full responsibility for the costs of non-covered tests. Red Bank Eye does not assume responsibility for costs of non-covered tests or services.

By entering your signature below you are acknowledging that you have read this entire agreement, understand all terms, verbiage (language) and concepts herein, and agree to proceed with care. You also affirm that you have discussed the services to be provided, the risks and benefits of said services, and the alternatives to these services, with an authorized representative of Red Bank Eye and have had all of your questions answered to your satisfaction.
By signing below you agree that you have weighed the risks and benefits of proceeding with the services and have decided that i t is in your best interest to obtain the services proposed.

I have sought the clinical services of Red Bank Eye, Red Bank, NJ – for my personal healthcare or for my child or children who are minors. I understand that this health practice may use some approaches, methods, and tests that may not be covered by my insurance plan, including Medicare. These tests, therapies, and approaches may include, but are not limited to, consultations, refractions, retinal fundus photography, corneal and contact lens evaluations, binocular vision evaluations, perceptual evaluations, and vision therapy.

Although prescriptions and over-the-counter medications are used when my physician deems it necessary, foods, vitamins, minerals, and other nutritional approaches may also be chosen as therapy or as adjunctive to vision therapies. It is my responsibility to ensure that I inform my primary and medical doctors of all supplements I will be taking so that he/she can make sure there are no contraindications with my other medications.

By signing this informed consent I agree to hold harmless Red Bank Eye, its owners, employees and contractors from all professional and personal liability, negligence, or other legal liability. I agree to be responsible for all legal costs and fees that may result from action(s) on my part or on the part of my representative(s) against Red Bank Eye.

SIGNATURE ON FILE: I request that my insurance provider, or Medicare, make either to me or on my behalf payment of authorized benefits to Red Bank Eye for services furnished to me. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand this consent agreement and have executed it freely and willingly.

_____

(Patient's Name and Signature) (Date)

_____

(Witness) (Date)