523 Forest Avenue Paramus, NJ 07652 Tel. (201) 262-5070 Fax (201) 262-5333
Scott B. Pomerantz, M.D. Thomas J. LoPresti, O.D.
Gayle Grossman, M.D. James A. Cindrario, O.D.

Please Complete and Sign Where Indicated

Patient Information:

Last Name:_____ **First Name:** _____

Date of Birth: _____/_____/_____ Age: _____ Soc. Sec. No.: _____-_____-_____

Street Address:_____ City:_____ State:_____ Zip Code_____

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____ Ext: _____

Cell Phone: (_____)_____-_____Email address:_____ Sex: M F

Occupation:_____ Employer:_____

Employer Address: _____

Insurance Co Name:_____

Primary Policy Holder: _____ Relationship to Patient: _____

Is the Patient a Student? Yes No If YES, Name of School: _____

Patient's Status: Single Married Separated Divorced Widowed

If you circled married, please complete Spouse Information below:

Spouse's Last Name: _____ **First Name:** _____

Date of Birth: _____/_____/_____ Soc. Security No.: _____-_____-_____

Is Spouse Currently Working? Yes No

Employer: _____ Employer Address: _____

Work Phone: (_____)_____-_____ Ext.: _____

How did you hear about our practice? (Name of person/website/newspaper)_____
Patient Name: _____**DOB:** _____ **Date:** _____

Emergency contact: Give the name of the nearest relative or of a close friend not living with you.

Name: _____ Home Phone: (_____) _____-_____

Relationship: _____ City: _____ State: _____

METRO EYE CARE

Comprehensive Patient History

Name:_____ **Date of Birth**: _____ **Date:** _____

Review of Systems

Do You Have?	**Yes**	**No**
Decreased vision……..	☐	☐
Flashes……...	☐	☐
Abnormal sensitivity to light…….	☐	☐
Halos around lights……	☐	☐
Problems with glare…….	☐	☐
Red eye……	☐	☐
Eye discomfort……	☐	☐
Eye dryness……...	☐	☐
Eye itching……..	☐	☐
Pressure in or behind the eye…	☐	☐
Tearing of the eyes……	☐	☐
Discharge……	☐	☐
Crusting or red eyelids……	☐	☐
Double vision……	☐	☐
Headaches……	☐	☐
Jagged lines in vision……	☐	☐
Distortion of vision……	☐	☐

Other illnesses:_____

_____

Other surgeries: _____

_____

Past Medical History

Have you ever had ?	**Yes**	**No**
Eye surgery……	☐	☐
Eye injury……	☐	☐
Serious eye infection……	☐	☐
Lazy eye……	☐	☐
Droopy eyelid……	☐	☐
Corneal disease……	☐	☐
Cataract……..	☐	☐
Retinal disorder……..	☐	☐
Eye tumor……	☐	☐
Eye turning in or out……..	☐	☐
Diabetes……..	☐	☐
High blood pressure……..	☐	☐
Heart disease……	☐	☐
Lung disease……	☐	☐
Neurological disease……	☐	☐
Thyroid disease……..	☐	☐
Migraine…… ..	☐	☐
Lupus…… ……..	☐	☐
Asthma…… …	☐	☐
Stroke…… …….	☐	☐
Glaucoma…… …….	☐	☐
Cancer……..……..	☐	☐
Cholesterol……..	☐	☐

Comprehensive Patient History

Name:_____ **Date of Birth**: _____ **Date:** _____

Family History	**Yes**	**No**
Cataracts……	☐	☐
Macular Degeneration……	☐	☐
Blindness……...	☐	☐
Retinal Detachment……	☐	☐
Glaucoma……..	☐	☐
Do you wear contact lenses?…….	☐	☐

If so, please provide any information you may have:

Soft Gas Perm. Toric

Disposable Extended wear

Name of Contact Lenses:

Present Prescription:

Base Curve (B.C.)

Diameter (Dia.)

Social history	**YES**	**No**
Do you smoke……	☐	☐
Are you pregnant……	☐	☐
Do you use a computer often…...	☐	☐
Do you consume alcohol…… …..	☐	☐
Other eye disorders……...	☐	☐
Do you wear glasses…… …	☐	☐

If so, what purpose: Distance Reading Bifocal

Progressive (Varilux) Trifocal Half /reader

Primary Care Provider:_____

Address:_____

Phone number: _____

Pharmacy Name:_____

Pharmacy Address:_____

Pharmacy Number:_____

List Allergies to medications if any:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Present Medication List: Dosage Freq.

Are you taking Flomax? Yes No

1. _____/_____/_____
2. _____/_____/_____
3. _____/_____/_____
4. _____/_____/_____
5. _____/_____/_____
6. _____/_____/_____
7. _____/_____/_____

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PAYMENT FOR SERVICES

In order to avoid misunderstanding regarding our payment policy, we ask that you read and sign the below.

It is your responsibility to know the provisions of your insurance plan.

Please give the receptionist your most updated INSURANCE card(s), LICENSE and REFERRAL (if your insurance company requires one for each office visit). All claims will be automatically submitted to your insurance company. Failure to provide our office with correct insurance information will result in a denial from your insurance company and your will ultimately be responsible for payment.

If you do not have insurance coverage or if the physician you are seeing does not participate with insurance plan, you will be responsible for payment at the completion of your exam.

All co-pays and refraction fees are due at the time of service. If your insurance company determines there is an additional subscriber liability (including, but not limited to deductibles, co-insurances, and non-covered services) you will be responsible for that amount.

Please understand that your insurance card is not a guarantee of payment of any health care claim. Final determination will be made based on your eligibility and benefits at the time of claim processing. .

Your signature below indicates that you have read and agree to our practice's payment for services policy.

(Patient /Guardian Signature)_____(Date) _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

By signing this form you acknowledge that you have received a copy and are aware of our Notice of Privacy Practices, effective September 23, 2013. You may request a new copy at any time.

Please read the statements below. By checking each individual box, you are giving our office the authorization to release your medical information.

- □ **Medical benefits to the physician or supplier.** By checking this box, you are allowing your insurance company to pay us for your office visit.
- □ **Medical information necessary to process this claim and all future claims.** By checking this box, you are allowing us to send your insurance company any information needed in order to process your claim.
- □ **Medical claims to be submitted electronically if your insurance company requires it.**
- □ **Your Pharmacy**. By checking this box you are allowing us to call in any prescription and/or refills on any of your eye medication(s).
- □ **Optician**. By checking this box, you are allowing us to give your eyeglass prescription to the optician of your choice.
- □ **Contact Lens Company**. By checking this box you are allowing us to give your contact lens prescription to the optician or contact lens company of your choice.
- □ Any other physician that requires information about you, such as your Primary Care Physician or any other Specialist.

X:_____ Date:_____
Signature

Please give us the name of a person that you would authorize us to release confidential information to, such as test results, billing questions or treatment.

Name:_____ Relationship:_____ Phone Number:_____

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One of the most important parts of your eye exam today is the refraction. This is the part of the exam that will determine whether you can be helped in any way by new glasses or contact lenses. It is also how we determine the best possible visual acuity and function of your eye, which is essential information for us to have as we assess your eyes and look for problems. **It is NOT a covered service by Medicare and many other insurance plans. These plans consider the refraction a "vision" service, not a "medical" service.** Our office fee for refraction is **$60.00** and unless your plan automatically covers the refraction charge, this fee is collected at the time of service in addition to any co-payment your plan may require.

Please place your **INITIAL**S on the line below to which your **VISION COVERAGE APPLIES:**

_____ I have vision coverage through **VSP (Vision Service Plan)**

_____ I have vision coverage through **IBEW Local Union 164**

If you **DO NOT HAVE VISION COVERAGE** and still would like the refraction done today, please **INITIAL** below:

_____ I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand that any co-payment, coinsurance, or deductible I may have are separate from, and not included in the refraction fee.
THIS FEE IS COLLECTED AT THE COMPLETION OF YOUR VISIT

If you would like to **DECLINE** the refraction service for today, or would like to **DEFER** the service until your next visit, please **INITIAL** below:

_____ I will decline or defer the refraction service today. I understand that without the refraction, the physicians may not be able to full assess the health and function of my eyes. If you decline the refraction, we will not be able to prescribe new eyeglass or contact lens prescriptions at this time.

Patient Signature:_____ Date:_____

Patient Name: (please print) _____