Eye Centers of America, LLC

523 Forest Ave
Paramus, NJ 07652

794 Franklin Ave Suite 201
Franklin Lakes, NJ 07417

Scott B. Pomerantz, M.D.
Seth W. Sachs, M.D.
Sejal Patel, M.D.

Thomas J. LoPresti, O.D.
James A. Cindrario, O.D.
Lee M. Angioletti, M.D.
James Kirszrot, M.D.

P- 201-262-5070 F- 201-262-5333

PATIENT REGISTRATION FORM

First Name	**MI** **Last Name**	**Suffix**	**Sex: M / F**
Home Address		**Date of Birth**	
City	**State**	**Zip Code**	
Preferred Language	Race ☐ Native American (Indian) ☐ Black/African American ☐ Asian		
Ethnicity ☐ Hispanic Origin. ☐ Not of Hispanic Origin	☐ Native Hawaiian/Pacific Islander ☐ Hispanic or Latino ☐ White		
Home #	Work #	Cell #	
Social Security #	Marital Status ☐ S ☐ M ☐ D ☐ W	E-mail	
Patients' Employer Name, Address / Occupation			
Emergency Contact Name	Phone #	Relationship	
Referring Physician/	Phone #	City	
Primary Care Physician	Phone #	City	
Financially responsible person (if different from patient)			
Responsible person's address:		Phone #	
***Are you currently residing in a Skilled Nursing Facility or Rehabilitation Center?		☐ Yes ☐ No	
Is this visit related to an automobile accident or Workers' Compensation?		☐ Yes ☐ No	

INSURANCE INFORMATION

Primary Insurance:	Policy Holder Name:	DOB:	Sex: M / F
Address:			
ID #:	Group #:	Effective Date:	
Secondary Insurance:	Policy Holder Name:	DOB:	Sex: M / F
Address:			
ID #:	Group #:	Effective Date:	

FINANCIAL POLICY STATEMENT

Thank you for choosing our practice for your medical care. We are committed to providing you with the highest quality services available. Please read and sign the following policy. If we are contracted with your insurance company, we will accept assignment. All co-pays, co-insurance and deductibles are due and payable at time of service. Failure to provide necessary referrals or current accurate billing information will result in all charges for services the sole responsibility of the patient/responsible party. You will be responsible for any balances not covered by your insurance. A return check fee of $35.00 will be assessed if your check is returned by your bank. Our cancellation and "no show" policy is as follows: First occurrence, patient will be charged a $25.00 fee. Second occurrence, patient will be charged a $35 fee. Third occurrence, patient will be charged a $50 fee. The patient may be charged the full price of the scheduled office visit for any additional "no show" or any appointment cancellation that occurs within 24 hours of a scheduled appointment.

HIPAA - This office will comply with all aspects as printed in our Notice of Privacy Practice, and our privacy notice will be in compliance with all appropriate laws and regulations.

PATIENT AUTHORIZATION

I hereby authorize Eye Centers of America, LLC to apply for benefits on my behalf for services rendered. I request payments from Medicare, Medigap, and/or any other insurance company be made directly to Eye Centers of America, LLC. I certify that the information I have provided on this form is correct. I authorize the release of any necessary information for this or any related claim to the above named carrier or in case of Medicare Part B benefits.

I hereby attest that I have been given and reviewed the Notice of Privacy Practice.

Patient Signature_____ Date _____

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HIPAA NOTICE OF PRIVACY PRACTICE

Privacy Consent

I understand that Eye Centers of America, LLC, "Notice of Privacy Practices" provides how my health information will be used and disclosed. The "Patient Rights" section describes my rights under the law. I have the right to review the notice before signing this consent. I understand that this notice may change and that I can request a revised copy. I understand that I have the right to request that we restrict how protected health information about me is disclosed for treatment, payment, or health care operations. I understand that Eye Centers of America, LLC, is not required to agree to this restriction, but you will honor this agreement.

I acknowledge by signing this form I consent to your use and disclosure to protect health information about my treatment, payment, and health care operations. I have the right to revoke this consent in writing with my signature. However, this revocation shall not affect any disclosures Eye Centers of America, LLC has already made in reliance prior to my consent. Eye Centers of America, LLC, provides this form to me to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Consent to Release Information

I acknowledge that by signing this form, I permit Eye Centers of America, LLC, to release any information to the physician(s) involved in my care. I consent that Eye Centers of America, LLC, may call my house or designated locations and leave a message on voice mail or in person in reference to my appointment reminders and insurance items. In addition, Eye Centers of America LLC, may mail to my home appointment reminders and patient statements.

I designate the following representative(s) as being legally authorized to communicate with Eye Centers of America, LLC, on my behalf. If you do not designate anyone below, the Doctor/Eye Centers of America, LLC, will not be able to speak with anyone besides the patient regarding your medical condition.

I acknowledge and give my consent to Eye Centers of America, LLC, to use the standard of care images taken of my eyes. These images will be used for submission to a 3rd party imaging vendor for certification purposes only. All personal identifiers will be removed prior to images being used.

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Signature on file

Patient Name:_____ Date of Birth: _____

Signature (Patient or Legal Guardian): _____ Date: _____

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PATIENT MEDICAL HISTORY FORM

Name: _____ Date of Birth: ___/___/_____ Height: _____ Weight: _____

REASON FOR REFERRAL / VISIT (TELL US WHY YOU ARE HERE):

_____

_____

_____

_____

CHIEF COMPLAINTS (TELL US WHAT IS BOTHERING YOU):

o Loss of Central Vision	o Glare from Bright Lights	o Swollen Eyelids
o Loss of Peripheral Vision	o Glare from Car Headlights	o Droopy Eyelids
o Loss of Night Vision	o Glare from the Sun	o Twitching of Eyelids
o Loss of Distance Vision	o Tearing from Bright Lights	o Floppy Eyelids
o Loss of Reading Vision	o Tearing from the Sun	o Poor Eyelid Closure
o Loss of Color Vision	o Headaches	o Bumps on Eyelid
o Flashes of Light	o Watery Discharge	o Growth on Eyelid
o Floaters	o Mucous Discharge	o Itchiness of Eyelids
o Shadow in Peripheral Vision	o Crusty Discharge	o Rash on Eyelids
o Distortion (of Straight Lines)	o Sand-Like Discharge	o Redness of Eyelids
o Objects Appear Smaller	o Aching Eye Pain	o Other:
o Sensitivity to Bright Lights	o Burning Eye Pain	o Do you wear contact lenses?
o Sensitivity to Car Headlights	o Pinching Eye Pain	o YES NO
o Sensitivity to the Sun	o Stabbing Eye Pain	o Brand:
o Halos Around Car Headlights	o Foreign Body Sensation	o RX RT: LT:

Location: What is the site of the problem/which eye? ☐ Right Eye ☐ Left Eye ☐ Both Eyes

Quality: What is the nature of the pain? ☐ Constant ☐ Intermittent ☐ Improving ☐ Worsening

Severity: Describe the severity of your pain/problem (on a scale of 1 to 10, with 10 being the worst) _____

Duration: When did the pain/problem start?_____

How long has the pain/problem been an issue?_____

Timing: Is the pain/problem worse in the morning, evening, or is it constant?_____

Context: Is the pain/problem associated with an activity? _____

Modifiers: What efforts has the patient made to improve the pain/problem (i.e. heat, artificial tears, other, etc.)?

_____

History: Is this visit related to an automobile accident or Workers' Compensation?_____

CONSTITUTIONAL SYMPTOMS

Good General Health Lately	☐Yes ☐No
Recent Weight Change	☐Yes ☐No
Fever	☐Yes ☐No
Fatigue	☐Yes ☐No
Headaches	☐Yes ☐No
Insomnia	☐Yes ☐No
Hours of Sleep Each Night	_____

PSYCHIATRIC

Memory Loss or Confusion	☐Yes ☐No
Nervousness	☐Yes ☐No
Depression	☐Yes ☐No
Insomnia	☐Yes ☐No
Anxiety	☐Yes ☐No

HEMATOLOGIC/LYMPHATIC

Slow to Heal After Cuts	☐Yes ☐No
Bleeding or Bruising Tendency	☐Yes ☐No
Anemia	☐Yes ☐No
Phlebitis	☐Yes ☐No
Past Transfusion	☐Yes ☐No
Enlarged Glands	☐Yes ☐No
Blood Transfusion	☐Yes ☐No
Transfusion Reaction	☐Yes ☐No

RESPIRATORY

Chronic or Frequent Cough	☐Yes ☐No
Spitting up Blood	☐Yes ☐No
Shortness of Breath	☐Yes ☐No
Asthma or Wheezing	☐Yes ☐No
Shortness of Breath While Walking or Lying	☐Yes ☐No
Recent Upper Respiratory Infection	☐Yes ☐No
Sleep Apnea	☐Yes ☐No

INTEGUMENTARY

Rash or Itching	☐Yes ☐No
Change in Skin Color	☐Yes ☐No
Change in Hair and Nails	☐Yes ☐No
Varicose Veins	☐Yes ☐No
Breast Pain	☐Yes ☐No
Breast Lump	☐Yes ☐No
Breast Discharge	☐Yes ☐No
Skin Disorders	☐Yes ☐No

NUTRITION

Supplements	☐Yes ☐No
Tube Feed	☐Yes ☐No
Eating Disorder	☐Yes ☐No
Vitamins/Minerals/Herbals	☐Yes ☐No
Liver Failure	☐Yes ☐No
Difficulty Swallowing	☐Yes ☐No
Unintentional Weight Loss in 3 months	☐Yes ☐No

MUSCULOSKELETAL

Arthritis	☐Yes ☐No
Joint Pain	☐Yes ☐No
Joint Stiffness or Swelling	☐Yes ☐No
Muscle or Joint Weakness	☐Yes ☐No
Muscle Pain or Cramps	☐Yes ☐No
Muscular Disorder	☐Yes ☐No
Back Pain	☐Yes ☐No
Cold Extremities	☐Yes ☐No
Difficulty in Walking	☐Yes ☐No
Spine Disease	☐Yes ☐No
Fractures	☐Yes ☐No

EAR, NOSE, MOUTH AND THROAT

Hearing Loss or Ringing	☐Yes ☐No
Hearing Aids	☐Yes ☐No
Earaches or Drainage	☐Yes ☐No
Chronic Virus Problems	☐Yes ☐No
Rhinitis	☐Yes ☐No
Nose Bleeds	☐Yes ☐No
Mouth Sores	☐Yes ☐No
Bleeding Gums	☐Yes ☐No
Bad Breath or Bad Taste	☐Yes ☐No
Sore Throat/Voice Change	☐Yes ☐No
Swollen Glands in Neck	☐Yes ☐No

NEUROLOGICAL

Frequent Urination	☐Yes ☐No
Light Headed or Dizzy	☐Yes ☐No
Convulsions or Seizures	☐Yes ☐No
Numbness or Tingling	☐Yes ☐No
Tremors	☐Yes ☐No
Weakness or Paralysis	☐Yes ☐No
Stroke	☐Yes ☐No
Head Injury	☐Yes ☐No
Speech Difficulties	☐Yes ☐No
Change in Gait	☐Yes ☐No
Vision Difficulties	☐Yes ☐No
Glasses/Contact Lenses	☐Yes ☐No

CARDIOVASCULAR

Heart Trouble	☐Yes ☐No
Chest Pain	☐Yes ☐No
Angina Pectoris	☐Yes ☐No
Palpitations	☐Yes ☐No
No Heat or Cold Intolerance	☐Yes ☐No
Swelling of Feet or Ankles	☐Yes ☐No
Pacemaker	☐Yes ☐No
Myocardial Infarction	☐Yes ☐No
Hypertension	☐Yes ☐No
Heart Failure	☐Yes ☐No
Valve Disease	☐Yes ☐No
Heart Murmur	☐Yes ☐No
Irregular Rhythm	☐Yes ☐No
High Cholesterol	☐Yes ☐No
Peripheral Vascular Disease	☐Yes ☐No

ENDOCRINE

Glandular or Hormonal Problems	☐Yes ☐No
Thyroid Disease	☐Yes ☐No
Excessive Thirst or Urination	☐Yes ☐No
Skin Becoming Dryer	☐Yes ☐No
Change in Hat or Glove Size	☐Yes ☐No
Diabetes	☐Yes ☐No
When were you diagnosed?	_____
Type 1 or Type 2 (Please Circle)	
HGB A1C/HbA1c?_____ Date:_____	
Are You on Insulin	☐Yes ☐No
Times Per Day	_____
Are You on Dialysis	☐Yes ☐No

GENITOURINARY

Frequent Urination	☐Yes ☐No
Burning or Painful Urination	☐Yes ☐No
Blood in Urine	☐Yes ☐No
Change in Force or Stream	☐Yes ☐No
Incontinence or Dribbling	☐Yes ☐No
Kidney Stones	☐Yes ☐No
Sexually Transmitted Disease	☐Yes ☐No
Sexual Difficulty	☐Yes ☐No
Male - Testicle Pain	☐Yes ☐No
Prostate Problems	☐Yes ☐No
Female - Pain with Periods	☐Yes ☐No
Female - Irregular Periods	☐Yes ☐No
HIV	☐Yes ☐No

GASTROINTESTINAL

Loss of Appetite	☐Yes ☐No
Change in Bowel Movements	☐Yes ☐No
Nausea or Vomiting	☐Yes ☐No
Frequent Diarrhea	☐Yes ☐No
Painful Bowel Movements or Constipation	☐Yes ☐No
Rectal Bleeding or Blood in Stool	☐Yes ☐No
Abdominal Pain or Heartburn	☐Yes ☐No
Peptic Ulcer (Stomach or Duodenal)	☐Yes ☐No
Hiatus Hernia	☐Yes ☐No
Gastrointestinal Problems	☐Yes ☐No
Hemorrhoids	☐Yes ☐No
Pancreatitis	☐Yes ☐No
Hepatitis	☐Yes ☐No
Liver Disease	☐Yes ☐No
Renal Disease	☐Yes ☐No

PAST MEDICAL HISTORY

Medical Condition	Year of Onset

CURRENT MEDICATIONS

Name	Dosage

PAST SURGICAL HISTORY

Surgeries	Date

Anesthesia Complications ☐Yes ☐No

If yes, explain:

PATIENT SOCIAL HISTORY

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Use of Tobacco
- ☐ Never
- ☐ Previous but Quit
- ☐ Currently
- _____ Packs Daily

Use of Illicit Drugs
- ☐ Never
- ☐ Type & Frequency

Use of Alcohol
- ☐ Never
- ☐ Rarely
- ☐ Moderate
- ☐ Daily

Excessive Exposure at Home or Work to:
- ☐ Fumes_____
- ☐ Solvents_____
- ☐ Chemicals_____
- ☐ Other_____

FAMILY MEDICAL HISTORY

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Brother(s)			
Sister(s)			
Spouse			
Children			

Living Will/Advance Directive ☐Yes ☐No ☐Would Like Information

LIST ALL ALLERGIES

PLEASE INFORM THE DOCTOR OF ALL PHYSICIANS

YOU ARE CURRENTLY SEEING

SPECIALTY	PHYSICIAN NAME	ADDRESS	PHONE NUMBER
Ophthalmologist			
Optometrist			
Internist			
Endocrinologist			
Cardiologist			
Nephrologist			
Neurologist			
Podiatrist			
Vascular Specialist			
Other			

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone # _____

METRO EYE CARE

A Division of Eye Centers of America

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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 eyes, 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 the refraction is **$65.00** 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 am aware that if I am seeing an MD today, my medical insurance will be billed as the primary insurance and VSP will be billed as secondary.**

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

_____ I have vision coverage through **Horizon Direct with NJX prefix**

_____ I have vision coverage through **Aetna Medicare**

We do NOT participate with Davis Vision, Spectera, NVA, Blue Vision.

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 fully assess the health and function of your eyes. If you decline the refraction, **the physicians will not be able to prescribe new eyeglass or contact lens prescriptions at this time**.

Patient Signature:_____ Date:_____

Patient Name: (please print) _____