ATLANTIC EYE

300 S HIGHWAY 35, SUITE 300. EATONTOWN, NJ 07724 | 732.222.7373
1963 NJ-34 BUILDING B, SUITE 101. WALL TOWNSHIP, NJ 07719 | 732.223.6555
100 COMMONS WAY # 230, HOLMDEL, NJ 07733 | 732.796.7140
180 WHITE ROAD, SUITE 202. LITTLE SILVER, NJ 07739 | 732.219.9220

PATIENT INFORMATION

Patient Information: Acct# _____ **Date:** _____

Patient Name: _____

Street Address: _____ **Male** ■ **Female** ■

City, State, Zip: _____

Date of Birth: _____ /_____ /_____ **Age:** _____ **Telephone (Home):** _____

Social Security #: _____ /_____ /_____ **Telephone (Work):** _____

Email: _____ **Telephone (Cell):** _____

EMPLOYMENT INFORMATION

Employer: _____ **Occupation:** _____

Address: _____

INSURANCE INFORMATION – PLEASE PRESENT ALL INSURANCE CARDS

Insurance Company: _____ **ID:** _____

Subscriber: _____ **S.S#:** _____ / _____ / _____ **DOB:** _____

Relation to Patient: _____

EMERGENCY CONTACT

Name: _____ **Telephone:** _____ / _____ / _____

PAYMENT OF PROFESSIONAL FEES

Full payment / Co-payments are due at the time of service.

We are a participating facility and accept assignment of Medicare benefits. You are STILL RESPONSIBLE for the Medicare deductible, 20% co-payment and Refraction fee. Medicare lifetime signature on file: "I request that payment of authorized Medicare benefits be made on my behalf to Atlantic Eye Physicians for any services furnished me by the physicians or supplier."

If your insurance company requires a referral prior to service, we cannot provide the service until YOU have secured the referral from your Primary Care Physician. "I have read and understand this document and authorize payment of any insurance benefits for unpaid services to the Atlantic Eye and understand that I am responsible for any balances or unpaid insurance claims. I authorize the release by Atlantic Eye of my medical information that is necessary to evaluate and pay my medical insurance claims."

Balances over 90 days will incur a finance charge of 1% per month on the unpaid balance – 12% APR.

By signing below, I acknowledge that I have read and understand all of the above information.

Patient Signature: _____ **Date:** _____ /_____ /_____

Patient Representative's Name: _____ **Relationship to Patient:** _____

ATLANTIC EYE

300 S HIGHWAY 35, SUITE 300. EATONTOWN, NJ 07724 | 732.222.7373
1963 NJ-34 BUILDING B, SUITE 101. WALL TOWNSHIP, NJ 07719 | 732.223.6555
100 COMMONS WAY # 230, HOLMDEL, NJ 07733 | 732.796.7140
180 WHITE ROAD, SUITE 202. LITTLE SILVER, NJ 07739 | 732.219.9220

PATIENT MEDICAL HISTORY

1. Name: _____ Birth Date: ____ / ____ / ____ / Date: _____

2. Name of Medical Doctor: _____ Phone: _____

3. Pharmacy: _____ Phone: _____

PLEASE LIST ALL OF YOUR MEDICATIONS

Brand Name: _____ Dose: _____ Frequency: _____
Brand Name: _____ Dose: _____ Frequency: _____
Brand Name: _____ Dose: _____ Frequency: _____
Brand Name: _____ Dose: _____ Frequency: _____
Brand Name: _____ Dose: _____ Frequency: _____
Brand Name: _____ Dose: _____ Frequency: _____

5. Do you have any drug allergies? Yes ■ No ■

Name of Drug(s) _____

Reaction _____

6. Do you have any Latex allergies? Yes ■ No ■

7. Do you smoke? Yes ■ No ■

8. Do you drink? Yes (how much) _____ No ■

9. Have you ever had a reaction to Anesthesia? Yes ■ No ■

If yes, what occurred? _____

10. Do you have a history of Fainting? Yes ■ No ■

11. Describe any Eye Surgery or Injury you have had (include date and Doctor who treated you)

_____ Date: _____ Doctor's Name: _____

12. Why are we examining you? _____

CIRCLE ANY BELOW THAT YOU HAVE NOW OR EVER HAD

○ Alzheimer/Dementia	○ Bronchitis	○ Heart Attack or Disease	○ Kidney Stones	○ Stroke/Paralysis
○ Anemia	○ Cancer	○ Heart Failure	○ Lymphoma	○ Type 1-Ins Dep
○ Angina	○ Convulsive Disorder	○ Hepatitis	○ Leukemia	○ Type 2-Non Ins Dep
○ Anxiety Disorder	○ Connective Tissue	○ HIV/AIDS	○ Nervous Disease	○ Thyroid Disorder
○ Arthritis	○ Diabetes	○ Hypertension	○ Obstructive Pulmonary Disease	○ Tuberculosis
○ Asthmas/Hayfever	○ Ear Disease	○ Hodgkin's	○ Pacemaker	
○ Back Problem	○ Emphysema	○ Irregular Heart Beat	○ Pneumonia	
○ Bladder Problem	○ Fracture(s)	○ Kidney Disease	○ Sinus Disease	

Other: _____

14. Does any family member (blood related) have/had a significant Eye disease?

If YES, who and describe; _____

ATLANTIC EYE

Atlantic Eye Physicians – Vision for the Future, *YOUR* future.

Listed below is helpful information on the testing being performed during your visit. If you have any questions, please let us know.

Dilating Eye Drops

Dilating eye drops enlarge the pupil of the eye to allow for the examination of the inside of your eye. These drops usually cause blurred vision. The length of time your vision will be blurred, and the degree of eyesight impairment varies from person to person.

Driving even in low light conditions may be difficult or impossible after an examination with dilating drops, and if possible, you should not drive yourself afterwards. Instead, we strongly suggest you make alternate arrangements for transportation after your examination. If you choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself or others. Also, we strongly suggest you use sunglasses to reduce your increased sensitivity to light while driving.

By signing below you authorize your Atlantic Eye provider and or their nurses or other assistants to administer dilating drops during the course of your treatment. You understand and acknowledge that you have been warned of the potential risks that dilating eye drops may have on your ability to drive and will take appropriate steps to reduce this risk.

Refraction Service and Fee

Refraction is the process of determining your best correct vision and if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and is necessary to write a prescription for glasses or contact lenses.

Refraction is **NOT** a covered service by Medicare or most insurance plans. These plans consider a refraction to be a "vision" service and not a "medical" service. If your plan includes vision coverage, this service is typically covered. We will file the charge for the refraction with your health insurance as a courtesy.

Our office fee for refraction is $55.00 and this fee is due at the time of service in addition to any co-payment your plan requires. Should your insurance pay us for the refraction, we will reimburse you accordingly.

Contact Lenses

Contact Lens evaluation, update of prescription, new fit and refit are **NOT** included in a routine eye exam. **There is an additional charge for this service. Payment is due at the time of service.**

Saturday No Show Fee

***** Our office requires a credit card on file for all Saturday appointments. A cancellation fee of $50 will be charged and applied for all No Shows or Cancellations made 24 hours or less. *****

By signing below you acknowledge that you have read this page in its entirety and understand the above stated information and fees and accept full financial responsibility for any cost incurred.

Patient Name_____ Date ____/____/____

Patient/Representative Signature_____

Representative_____ Relation to Patient_____

ATLANTIC EYE

300 S HIGHWAY 35, SUITE 300. EATONTOWN, NJ 07724 | 732.222.7373
1963 NJ-34 BUILDING B, SUITE 101. WALL TOWNSHIP, NJ 07719 | 732.223.6555
100 COMMONS WAY # 230, HOLMDEL, NJ 07733 | 732.796.7140
180 WHITE ROAD, SUITE 202. LITTLE SILVER, NJ 07739 | 732.219.9220

PAYMENT OF PROFESSIONAL FEES

Full payment / Co-payments are due at the time of service.

We are a participating facility and accept assignment of *Medicare* benefits. You are STILL RESPONSIBLE for the Medicare deductible, 20% co-payment and Refraction fee. Medicare lifetime signature on file: "I request that payment of authorized Medicare benefits be made on my behalf to Atlantic Eye Physicians for any services furnished me by the physicians or supplier."

If your insurance company requires a referral prior to service, we cannot provide the service until YOU have secured the referral from your Primary Care Physician. "I have read and understand this document and authorize payment of any insurance benefits for unpaid services to the Atlantic Eye Physicians and understand that I am responsible for any balances or unpaid insurance claims. I authorize the release by Atlantic Eye Physicians of my medical information that is necessary to evaluate and pay my medical insurance claims."

NOTICE OF PRIVACY POLICIES

The following policy describes how your medical information may be used and disclosed by the Atlantic Eye Physicians, PA and/or the Atlantic Surgery Center. Please review it carefully. The privacy of your health information is important to us. This notice is being supplied as a part of our requirements of the health insurance portability and accountability act **(HIPAA)** that became effective on April 14, 2003 and updated September 23, 2013 (Final Omnibus Rule).

Please list the full names of the people you authorize to have access of your medical information:

_____ _____ _____

_____ _____ _____

Do you authorize Atlantic Eye Physicians to leave messages containing your medical information for you on your home and/or cell phone? YES ■ NO ■

By signing below, I acknowledge that I have read and understand all of the above information.

Patient Name:_____ Date _____

Representative _____ Relation to Patient _____