

Retina Vitreous Consultants NJ

349 East Northfield Road, Suite 100
Livingston, New Jersey 07039
P: 973-716-0123 F: 973-716-0441

95 Madison Avenue, Suite A03
Morristown, New Jersey 07960
P: 973-605-1114 F: 973-716-0441

PATIENT INFORMATION

NAME (LAST, FIRST)		SEX	SS#	BIRTHDATE	LANGUAGE	SMOKER YES/ NO
LOCAL ADDRESS		CITY, STATE, ZIP			HOME PHONE	
BILLING ADDRESS		CITY, STATE, ZIP			CELL PHONE	
MARITAL STATUS	STUDENT STATUS (Y/N) FULL TIME/ PART TIME	VETERAN YES / NO	EMAIL		WORK PHONE	
How do you prefer we confirm your future appointments? Call _____ Text _____ Email _____						
OK to leave a message containing personal information YES/NO			Best contact phone: Home / Cell/ Work			
EMERGENCY CONTACT NAME / RELATION			CONTACT PHONE		CONTACT HOME PHONE	
REFERRING DOCTOR			PRIMARY CARE PHYSICIAN			

RESPONSIBLE PARTY INFORMATION (if different than above)

NAME	RELATION	BIRTHDATE	PHONE
STREET ADDRESS		CITY, STATE, ZIP	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		NAME OF INSURED/ RELATION			
POLICY NUMBER		GROUP NUMBER			
INSURED D.O.B	INSURED S.S #	COPAY AMMOUNT \$	DEDUCTIBLE \$		
ADDRESS OF INSURANCE COMPANY		CITY, STATE, ZIP			PHONE

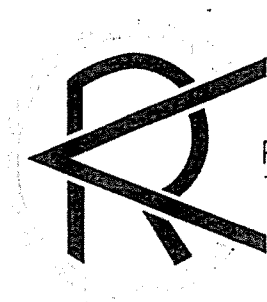
SECONDARY INSURANCE (if applicable)

NAME OF INSURANCE COMPANY		NAME OF INSURED/ RELATION			
POLICY NUMBER		GROUP NUMBER			
INSURED D.O.B	INSURED S.S #	COPAY AMMOUNT \$	DEDUCTIBLE \$		
ADDRESS OF INSURANCE COMPANY		CITY, STATE, ZIP			PHONE

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT ANY INTEREST of 1.5% and a \$50.00 collection fee MAY BE CHARGED on all balances owed to the provider that are past due.

Signature _____
(signature of insured or authorized person, patient, or parent if minor)

Date: ____ / ____ / ____



RETINA-VITREOUS CONSULTANTS

TINA XIA, M.D.

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rvc-nj.com

INSURANCE COMPANIES WILL NOT PAY PROVIDERS IF CLAIMS ARE NOT SUBMITTED WITHIN 60 DAYS. THEREFORE, IT IS IMPERITIVE FOR OUR PATIENTS TO PROVIDE THE CORRECT INSURANCE INFORMATION AT THE TIME OF SERVICE.

IF I, _____, DO NOT PROVIDE THE CORRECT INSURANCE AT THE TIME OF VISIT, I AM FULLY RESPONSIBLE FOR ANY UNPAID CHARGES.

SIGNATURE OF RESPONSIBLE PARTY

DATE

RETINA-VITREOUS CONSULTANTS NJ

I understand that professional services are rendered to the patient and that patient is responsible for the charges incurred. I understand that I am financially responsible for the charges not covered by my insurance company. I understand that the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I understand that any balance left unpaid will be subject to an interest rate of 1.5% monthly and a \$50.00 Collection Fee. There will be a \$30.00 fee for all returned checks.

Signature _____

I voluntarily consent to such care and treatment as prescribed by the physician.

Initial _____

I acknowledge that I have received a copy of Retina-Vitreous Consultants NJ Privacy Act.

Initial _____

I hereby authorize the following people to have full access to my medical information and records:

I hereby give permission for the office to contact the following people regarding any financial questions that may arise during the course of my treatment:

By my signature below, I acknowledge that I have received Retina-Vitreous Consultants NJ/Tian Xia MD PA Notice of Privacy Practices and I authorize the release of my private healthcare information for the purposes of treatment, payment and healthcare operations.

Name (print)

Signature

Date

Diabetes Type I..... YES NO Date of onset: _____

Last Blood Sugar: _____

Last A1C: _____ Date: _____

Diabetes Type II..... YES NO Date of onset: _____

Last Blood Sugar: _____

Last A1C: _____ Date: _____

Medical History:

Diagnosis			Year	Treatment	When
Thyroid Disease	YES	NO	_____	_____	_____
Palpitations	YES	NO	_____	_____	_____
High Blood Pressure	YES	NO	_____	_____	_____
Heart Attack	YES	NO	_____	_____	_____
Pacemaker	YES	NO	_____	_____	_____
Carotid Artery Disease	YES	NO	_____	_____	_____
Angioplasty/Bypass	YES	NO	_____	_____	_____
Elevated Cholesterol	YES	NO	_____	_____	_____
Anemia	YES	NO	_____	_____	_____
Sickle Cell	YES	NO	_____	_____	_____
Immune Deficiency	YES	NO	_____	_____	_____
Lupus	YES	NO	_____	_____	_____
HIV/AIDS	YES	NO	_____	_____	_____
Sarcoidosis	YES	NO	_____	_____	_____
Hepatitis	YES	NO	_____	Type: _____	_____
Gallbladder	YES	NO	_____	_____	_____
Inflammatory Bowel	YES	NO	_____	_____	_____
Stroke	YES	NO	_____	_____	_____
Seizures	YES	NO	_____	_____	_____
Multiple Sclerosis	YES	NO	_____	_____	_____
Headaches	YES	NO	_____	_____	_____
Prostate Disease	YES	NO	_____	_____	_____
Renal Failure	YES	NO	_____	_____	_____
Rheumatoid Arthritis	YES	NO	_____	_____	_____
Dementia	YES	NO	_____	_____	_____
Alzheimer's	YES	NO	_____	_____	_____
Depression	YES	NO	_____	_____	_____
Cancer	YES	NO	_____	Type: _____	_____
Asthma	YES	NO	_____	_____	_____
Emphysema	YES	NO	_____	_____	_____
Tuberculosis	YES	NO	_____	_____	_____

Please list any additional conditions and surgeries below:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History:

	YES	NO	Relation
Amblyopia	YES	NO	_____
Blindness	YES	NO	_____
Diabetic Eye	YES	NO	_____
Cataracts	YES	NO	_____
Glaucoma	YES	NO	_____
Macular Degeneration	YES	NO	_____
Retinal Detachment	YES	NO	_____
Retinal Disorders	YES	NO	_____
Sickle Cell	YES	NO	_____
Strabismus	YES	NO	_____

Have **YOU** had any:

Eye surgery	YES	NO	Glaucoma	YES	NO
Laser treatments	YES	NO	Decrease in vision	YES	NO
Eye Prescriptions	YES	NO	Floaters	YES	NO
Eye Trauma	YES	NO	Flashes	YES	NO
Corrective glasses	YES	NO			

Social History:

Do you smoke?	YES	NO	How Long? _____	When did you quit?
Alcohol Use:	YES	NO	How Much? _____	
Recreational drug use:	YES	NO		
Do you use caffeine:	YES	NO	How much caffeine do you consume per day?	_____

List all Physicians:

Name & Specialty	Address:	Phone & Fax #'s

Can we contact your pharmacy for a complete list of your medication? YES NO

Pharmacy, Address & Phone#: _____

Reviewed with patient: _____ Date: _____