Livingston Vitreo Retinal Associates
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

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 $35.00 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: ____/____/_____

Medical History

Patient Name: _____ Today's Date_____

Reason for todays visit: _____

Onset of symptoms: _____

Do you wear glasses? YES NO **Circle One** (Near, far, bifocal)

Medications (including eye drops, vitamins, herbs and over the counter meds including Aspirin & pain relievers):

Name	**Dose**	**Frequency**

Medication Allergies:

Drug	**Reaction**

Environmental Allergies:

	Reaction

Past Ocular History and Surgeries:

Condition			**Date Diagnosed**	**Treatment**	**Eye**
Glaucoma	YES	NO			
Macular Degeneration	YES	NO			
Diabetic Eye Disease	YES	NO			
Retinal Detachment	YES	NO			
Cataracts	YES	NO			

Please list any additional ocular conditions below:

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/Bipass	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:

			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: _____

RETINA-VITREOUS CONSULTANTS
LIVINGSTON VITREO-RETINAL ASSOCIATES

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 $25.00 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 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/Livingston Vitreo-Retinal Assoc. 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