PLEASE PRINT! DATE: _____

NAME: DR / MR / MRS / MS _____

TELEPHONE: HOME: _____ WORK: _____ CELL: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

BIRTHDATE: _____ SS#: _____

MARITAL STATUS: S M W D SPOUSE'S NAME: _____

RACE: ASIAN | AFRICAN AMERICAN | HISPANIC | WHITE **E-MAIL ADDRESS:** _____

LANGUAGE: ENGLISH OTHER SIGN LANGUAGE SPANISH

OCCUPATION: _____ WHO REFERRED YOU? _____

MEDICAL DR'S NAME AND ADDRESS: _____

MEDICAL DR'S Phone Number: _____

REASON FOR APPOINTMENT? _____

INSURANCE PRIMARY: _____ POLICY HOLDER: _____

DATE OF BIRTH OF POLICY HOLDER: _____

INSURANCE SECONDARY: _____ POLICY HOLDER: _____

DATE OF BIRTH OF POLICY HOLDER: _____

IN ORDER TO CONTROL THE COST OF BILLING WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. ROUTINE/VISION EYE CARE IS NOT COVERED BY MEDICARE OR MOST OTHER INSURANCE COMPANIES. **WE DO NOT PARTICIPATE WITH ANY VISION PLANS, such as VSP / Spectera / Davis Vision / EyeMed / Cole Vision / Benny Vision / MetLife Vision , etc...** It is your responsibility to pay the deductible, co-insurance or any other balance not paid by your insurance.

***THE REFRACTIVE PART OF YOUR EXAM IS A NON-COVERED SERVICE AND TO BE PAID BY THE PATIENT, THAT FEE IS $30.00.**

***THERE IS A REFIT FEE FOR CONTACT LENS USERS OF $50.00.**

I understand that I am financially responsible for all charges whether or not paid by said insurance. It is the patients responsibility to know the order of his/her insurance, if claims are denied due to patients error the patient will be fully responsible for payment.
I hereby authorize said assignee to release all information necessary to secure payment from my insurance company. I authorize my insurance company to release any information to Dr. Macdonald's office regarding reimbursement for my claims.

SIGNED _____

PLEASE PRESENT ALL INSURANCE CARDS TO RECEPTIONIST! THANK YOU!

ROUTINE EYE EXAMS ARE NOT COVERED BY YOUR MEDICAL INSURANCE UNLESS YOU HAVE VISION CARE BENEFITS!!

PLEASE SEE NEXT PAGE!!

MEDICAL HISTORY UPDATE

NAME: _____ DATE: _____

EMERGENCY CONTACT: _____ PHONE: _____

PHARMACY NAME / TOWN: _____

PHARMACY PHONE: _____

MEDICAL PROBLEMS (diabetes, etc…) : _____

_____

_____

ALL MEDICATIONS: _____

_____

_____

ALL ALLERGIES: _____

_____

SOCIAL HISTORY:

DO YOU DRIVE?	YES	NO
DO YOU HAVE DIFFICULTY DRIVING?	YES	NO
HAVE YOU EVER WORN CONTACTS?	YES	NO
DO YOU WEAR GLASSES?	YES	NO
HAVE YOU SMOKED MORE THAN 100 CIGARETTES IN YOUR LIFETIME?	YES	NO
IF **YES** SMOKING STATUS : EVERY DAY SOME DAYS FORMER SMOKER		
SMOKELESS TOBACCO (Chewing Tobacco)	YES	NO

LIST ANY SURGERY YOU HAVE HAD:

_____

FAMILY HISTORY:

DO YOU HAVE A FAMILY HISTORY OF GLAUCOMA OR BLINDNESS?

MONMOUTH EYE CARE
21 GILBERT STREET NORTH
SUITE 200
TINTON FALLS, N.J. 07701

TEL. 732-741-1902 / FAX 732-741-1919

HIPAA

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:

- Myself only
- My spouse or significant other (specify name) _____
- My parent(s) (specify name) _____
- Other (specify name) _____

Information to be disclosed:

- Laboratory results
- Medications
- All information
- Other test results (specify) _____

I would like to be contacted at my:

- Home phone _____
- Work phone _____
- Cell phone _____
- Mail
- E-mail address: _____

Regarding the office staff or physician leaving information or confirming appointments on my answering machine, voice mail/e-mail or with my answering service?

- No, I do not want any information left on my answering system
- Yes, I give my permission for only non medical messages and appointment reminders to be left on my answering system
- Yes, I give my permission for medical information and non medical messages and appointment reminders to be left on my message system

This authorization shall be in force and effect until revoked at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to our office at the above address. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal HIPAA Privacy Rule or state law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Date