Adam S. Friend, M.D. Kunal Y. Merchant, M.D. James Kirszrot, M.D.
65 Harristown Rd #302, Glen Rock, NJ 07452
Ph. (201) 797-5100 Fax. (201) 797-4160

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
Patient's Employer Name, Address / Occupation		
Emergency Contact Name	Phone #	Relationship
Referred by:	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
Secondary Insurance:	Policy Holder Name:	DOB:	Sex: M / F
Vision Insurance:			

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 the assignment. All co-pays, co-insurance, and deductibles are due and payable at the time of service. Failure to provide necessary referrals or current accurate billing information will result in all charges for services being 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 $36.00 will be assessed if your check is returned by your bank. Our cancellation and "no show" policy is as follows: First occurrence, the patient will be charged a $25.00 fee. For the second occurrence, the patient will be charged a $35 fee. Third occurrence, the 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 the case of Medicare Part B benefits. I agree to allow Eye Centers of America to file an appeal on my behalf with my health plan.

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 healthcare 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 the 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 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

Patient Name:____ Date of Birth: ____________________

Signature (Patient or Legal Guardian): __________________________________ Date: ____________________

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NEW 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):

○ Loss of Central Vision	○ Glare from Bright Lights	○ Swollen Eyelids
○ Loss of Peripheral Vision	○ Glare from Car Headlights	○ Droopy Eyelids
○ Loss of Night Vision	○ Glare from the Sun	○ Twitching of Eyelids
○ Loss of Distance Vision	○ Tearing from Bright Lights	○ Floppy Eyelids
○ Loss of Reading Vision	○ Tearing from the Sun	○ Poor Eyelid Closure
○ Loss of Color Vision	○ Headaches	○ Bumps on Eyelid
○ Flashes of Light	○ Watery Discharge	○ Growth on Eyelid
○ Floaters	○ Mucous Discharge	○ Itchiness of Eyelids
○ Shadow in Peripheral Vision	○ Crusty Discharge	○ Rash on Eyelids
○ Distortion (of Straight Lines)	○ Sand-Like Discharge	○ Redness of Eyelids
○ Objects Appear Smaller	○ Aching Eye Pain	○ Other:
○ Sensitivity to Bright Lights	○ Burning Eye Pain	○
○ Sensitivity to Car Headlights	○ Pinching Eye Pain	○
○ Sensitivity to the Sun	○ Stabbing Eye Pain	○
○ Halos Around Car Headlights	○ Foreign Body Sensation	○

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, or 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
- Lightheaded 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

GENITROURINARY

- 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, the 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 # ______________________