Pompton Eye & Vision Care, LLC

496 Newark Pompton Tpke.
Pompton Plains, NJ 07444
973.835.7000

Note: Insert in printer with front page up, bottom first

Today's Date _____

Legal Name _____ _____ _____
First MI Last

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Birth Date _____ Social Security # _____ Last Eye Exam _____

Personal Email Address _____ Occupation _____

Employer _____ Address _____

Current student: Enter present grade level _____

Hobbies/Activities _____

Health Insurance _____ Primary Care Physician

ID # _____ Name _____

Group # _____ Address _____

Vision Coverage _____ Phone _____

ID # _____

Group # _____ Date of last visit _____

Date of last tetanus shot _____

Medicare # (if applicable) _____

How did you hear about our office? _____

If child is under 18 years of age, guarantor (person responsible for payment) is:

Name _____ Address _____

CONTACT LENS FEES

Insurance carriers will not cover procedures related to contact lenses unless they are medically necessary. Please note, most contact lenses are for cosmetic purposes.

PAYMENT POLICY

Insurance and Managed Care Plans *-- If we are participating providers with your insurance plan, your claims will be submitted by our office. Co-payments are due at the time of service.*

Medicare *-- Our office is a participating provider for Medicare. We will submit all claims for approved services.*

Patients not covered by these plans *-- You are requested to pay at the time of your visit. A receipt is provided to submit to your insurance company for reimbursement.*

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare or other assigned insurance be made directly to William Ference, O.D. c/o Pompton Eye & Vision Care, LLC for any services rendered. I authorize any holder of medical information about me to release to the HCFA (Health Care Financing Administration) and its agents any information needed to determine these benefits payable for related services.

I understand that I am fully responsible for any non-covered services.

Signature _____ Date _____
(Parent/guardian, if under 18)

********************PLEASE COMPLETE THE MEDICAL INFORMATION ON THE BACK OF THIS FORM***********************

Medical Information

Allergies Y/N To what? _____ What happens? _____

Do you have problems with any of these systems? *(please circle all that apply)*

Allergic	Y/N	Genitourinary	Y/N	Integumentary (skin)	Y/N
Cardiovascular	Y/N	Ears/Nose/Throat	Y/N	Musculoskeletal	Y/N
Endocrine (glands)	Y/N	Blood/lymph	Y/N	Neurological	Y/N
Gastrointestinal	Y/N	Immunologic	Y/N	Mental	Y/N
				Respiratory	Y/N

Please explain _____

Please answer all that apply:

Do you have headaches? Y/N Are you pregnant or nursing? Y/N

Medication allergy Y/N

Diabetes Y/N Type: NIDDM IDDM *(please circle)* Date of diagnosis _____

Last glucose/HA1C reading: _____ Date of reading: _____

Other health problems? _____

Current medications (s) _____

Have you had any operations? Y/N Kind? _____ When? _____

Do you use cigarettes/tobacco? Y/N Alcohol? Y/N Other substance(s)? _____

Family History

High blood pressure	Y/N	Relation	_____				
Diabetes	Y/N	Relation	_____	Macular degeneration	Y/N	Relation	_____
Glaucoma	Y/N	Relation	_____	Retinal detachment	Y/N	Relation	_____
Cataracts	Y/N	Relation	_____	If yes, Cataract Surgery	Y/N	Relation	_____
Other eye condition(s)	Y/N	What kind?	_____			Relation	_____

Personal Eye Information

Have you had any eye operations?	Y/N	Type	_____			Date	_____
Have you had an eye injury?	Y/N	Kind	_____			Date	_____
Do you have glaucoma?	Y/N	Cataracts?	Y/N	Dry eyes?	Y/N	Blurred vision?	Y/N
Other eye problems?	Y/N	What kind?	_____				
Do you wear glasses?	Y/N	Contact lenses?	Y/N	Type	_____		

Additional information _____