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: _____

E-MAIL ADDRESS: (PLEASE print) _____

RACE: ASIAN **|** AFRICAN AMERICAN **|** HISPANIC **|** WHITE **LANGUAGE:** ENGLISH | OTHER | SIGN LANGUAGE | SPANISH

YOUR OCCUPATION: _____

MEDICAL DR'S NAME AND ADDRESS: _____

MEDICAL DR'S Phone Number: _____

REASON FOR APPOINTMENT? YEARLY EXAM FOLLOW-UP EYE PROBLEM _____

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 CO-PAYS AND DEDUCTIBLES 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.

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

***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 FOR $50.00.**

I understand that I am financially responsible for all charges whether or not paid by said insurance. It is the patient's responsibility to know the order of his/her insurance, if claims are denied due to patient's 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!

LIKE US ON FACEBOOK...
VISIT US AT WWW.MONMOUTHEYECARE.COM

MEDICAL HISTORY UPDATE

NAME: _____ DATE: _____

EMERGENCY CONTACT: _____ PHONE: _____

PHARMACY NAME / TOWN: _____

Please CHECK any conditions or illnesses you have NOW or EVER had.

O Anemia	O Anxiety	O Arrhythmia	O Arthritis	O Asthma
O Cancer	O Chronic Bronchitis	O Chronic Sinus	O Congestive heart failure	O Diabetes
O Dementia	O Depression	O Emphysema	O Hard of Hearing	O Heart Attack
O Hepatitis	O High Cholesterol	O HIV	O Hypertension	O Multiple Sclerosis
O Pacemaker	O Parkinson's Disease	O Seizure	O Stroke	O Thyroid

Any other MEDICAL PROBLEMS not listed above: _____

_____

ALL MEDICATIONS: _____

_____

_____

ALL ALLERGIES: _____

_____

SOCIAL HISTORY:

1. DO YOU DRIVE? YES NO
2. DO YOU HAVE DIFFICULTY DRIVING? YES NO
3. DO YOU WEAR CONTACTS? YES NO
4. DO YOU WEAR GLASSES? YES NO
5. HAVE YOU HAD CATARACT SURGERY? YES NO
6. HAVE YOU SMOKED MORE THAN 100 CIGARETTES IN YOUR LIFETIME? YES NO

   IF **YES** SMOKING STATUS : EVERY DAY SOME DAYS FORMER SMOKER
7. **DO YOU USE *SMOKELESS TOBACCO*** *(Chewing Tobacco)* YES NO
8. Do you have any family history of Glaucoma or Blindness? YES NO

   IF YES please list who has/had any eye disease. _____

   IF YES please circle Maternal or Paternal

LIST ANY SURGERY YOU HAVE HAD IN THE PAST FIVE YEARS:

_____

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:

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

Information to be disclosed:

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

I would like to be contacted at my:

- a Home phone _____ a Work phone _____
- a Cell phone _____ a Mail
- a 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?

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