Monroe Eye Care

Welcome to our practice – Home for all your Eye care needs!

Today's Date____________________

Patient Information

Last name_____________________ First name________________ MI_____ Gender: M____ F______

Address____________________________ City_______________________ State_____ Zip___________

Work phone (   )____________ Home phone (   )________________ Cell (   )_________________

DOB__________________ Age__________ Patient's SSN ___________________________________

E-mail Address_________________________ Spouse (or Parent's Name)___________________________

Occupation (or Grade)___________________ Employer (or School)______________________________

Date of last eye exam____________________ Dilated? Yes/No

Whom may we thank for referring you? : Insurance List___ Saw Sign/Building___ Direct Marketing__
Web Page___ Another Dr.___ Other___

Insurance Information

Vision Insurance___________________________

Subscriber's Name_________________________
Subscriber's SSN__________________________
Subscriber's DOB_________________________

Primary Medical Insurance_________________

Subscriber's Name_______________________
Subscriber's SSN________________________
Subscriber's DOB________________________

Patient Eye History

Date of Last Eye Exam________________________

By Whom?_________________________________

Do you use a computer majority of the day? Yes/No

Do you experience Eye Fatigue while using a computer or prolonged reading? Yes/No

Do you currently wear glasses? Yes/No
How is your vision with glasses? Clear/ Blurred

Do you currently wear contact lenses? Yes/No
What type? ___________________
How is your vision with contacts? Clear/Blurred
Are you comfortable wearing contacts? Yes/No

MEDICAL HISTORY YOUR NAME: TODAY'S DATE:

CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS-Why are you here today?

List all eye health problems/symptoms*:______________________________

**Medical insurance will only cover if there is a medical reason for the exam such as loss of vision, headaches, eye redness, eye pain, eye itching, glaucoma, cataracts, floaters, dry eyes, etc.*

Please answer the following by circling:

Location	**Which eye has the problem?**	Right eye – Left eye – Both eyes
Quality	**Does the problem cause vision loss or blur?**	Loss – Blur
Context	**Did the problem occur suddenly or gradual?**	Sudden – Gradual
Severity	**How severe is the problem?**	Mild – Moderate – Severe
Modifying Factors	**Is it worse at any specific distance?**	Distance – Near –Computer
Duration	**How long does the problem last?**	Intermittent – Constant
Timing	**How long has the problem been occurring?**	Short term – Long term
Associated Symptoms	**Are there associated symptoms?**	No – Headache – Pain - Light Sensitivity – Other____________
Previous Interventions	**Does anything help the problem?**	Nothing helps – Nothing has been tried-Other_______________

PAST, FAMILY AND/OR SOCIAL HISTORY- Please answer the following. Please write NA, if it does not apply. (1, 3)

Personal Medical History:

Have you had any major illnesses, injuries, or operations? [ ] Y [ ] N Explain:__________________________

Are you taking any medications (prescription and over-the-counter)? [ ] Y [ ] N List: ______________________

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Date of Last Medical Exam: ______________ Doctor: __________________________ For women: Pregnant/nursing? [ ] Y [ ] N

Family Health History: Please circle any condition in your family history and indicate relative affected.

Glaucoma	______________	Corneal Problem	_______________	Diabetes	_______________
Macular Degen	______________	Crossed eyes	_______________	Heart Disease	_______________
Retinal Problem	______________	Lazy eye	_______________	High Blood Pressure	_______________

Social History: Your occupation/grade: ________________________ Place of employment/school:________________________

List your sports, hobbies, or special visual needs:______________________________________

How many hours do use a computer a day? _____ Have you been exposed to Herpes, HIV, TB, Hepatitis? [ ] Y [ ] N ________

Do you use tobacco products? [ ] Y [ ] N Do you drink alcohol? [ ] Y [ ] N Do you use recreational drugs? [ ] Y [ ] N

REVIEW OF SYSTEMS – Check inside the boxes if you have a problem with any of the following: (1, 2, 10)

Eyes	**Y**	**N**
Loss of vision	[ ]	[ ]
Blurred vision	[ ]	[ ]
Double vision	[ ]	[ ]
Cataracts	[ ]	[ ]
Crossed eyes	[ ]	[ ]
Flashes	[ ]	[ ]
Floaters	[ ]	[ ]
Dry eyes	[ ]	[ ]
Watery eyes	[ ]	[ ]
Red eyes	[ ]	[ ]
Mucous discharge	[ ]	[ ]
Burning or itching	[ ]	[ ]
Sandy or gritty feeling	[ ]	[ ]
Eye pain or soreness	[ ]	[ ]
Light sensitivity	[ ]	[ ]
Chronic eye infections	[ ]	[ ]
Tired eyes/Eyestrain	[ ]	[ ]
Halos/Glare	[ ]	[ ]
Previous Vision Therapy	[ ]	[ ]
Previous Eye surgery	[ ]	[ ]
Previous Eye injury	[ ]	[ ]
Retinal detachment	[ ]	[ ]
Glaucoma	[ ]	[ ]

If you answered yes to eye injury or eye surgery, please explain :

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Allergic/Immunologic	**Y**	**N**
Hay fever/Allergies	[ ]	[ ]
Medicine allergies	[ ]	[ ]
Lupus	[ ]	[ ]
Sjogrens	[ ]	[ ]
Constitutional symptoms		
Fever	[ ]	[ ]
Recent Weight loss	[ ]	[ ]
Cardiovascular		
Heart disorder	[ ]	[ ]
High blood pressure	[ ]	[ ]
Vascular disease	[ ]	[ ]
Ears, Nose, Mouth, Throat		
Sinus problems	[ ]	[ ]
Dry throat/mouth	[ ]	[ ]
Chronic ear infections	[ ]	[ ]
Endocrine		
Diabetes	[ ]	[ ]
Thyroid problems	[ ]	[ ]
Other glands	[ ]	[ ]

If you answered YES to high blood pressure, what was your last blood pressure measurement? _______________

If you answered YES to diabetes, when were you diagnosed? ________________

List your last Blood Sugar: _____________

List your last Hemoglobin A1C: _________

Genitourinary	**Y**	**N**
Genitals	[ ]	[ ]
Kidneys or Bladder	[ ]	[ ]
Hematologic/Lymphatic		
Anemia	[ ]	[ ]
High cholesterol	[ ]	[ ]
Integumentary		
Skin	[ ]	[ ]
Breast	[ ]	[ ]
Musculoskeletal		
Arthritis	[ ]	[ ]
Rheumatoid Arthritis	[ ]	[ ]
Muscle pain/Joint pain	[ ]	[ ]
Neurological		
Headaches	[ ]	[ ]
Migraines	[ ]	[ ]
Seizures	[ ]	[ ]
Multiple Sclerosis	[ ]	[ ]
Psychiatric		
Nervous disorders	[ ]	[ ]
Depression	[ ]	[ ]
Respiratory		
Asthma	[ ]	[ ]
Shortness of breath	[ ]	[ ]
Emphysema	[ ]	[ ]
Lung cancer	[ ]	[ ]

List any other medical conditions not listed above:________________________________

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1600 Perrineville Rd., Suite 32, Monroe Twp, New Jersey 08831 Tel. 609-235-9770

Dilated Fundus Exam

- The New Jersey Board of Optometry has established that a comprehensive eye exam for a new patient include a Dilated Fundus Exam. This procedure involves putting drops in each eye that will enlarge the pupils. Dr. Miglani will then examine the internal structures of the eye to ensure proper health. The drops cause light sensitivity and blur vision for 2-4 hours. Most individuals can safely drive after this procedure. There is no additional charge for this dilation.

__________ I agree to have my eyes dilated today.

__________ I do **NOT** agree to have my eyes dilated today.

Visual Field Screening Test

- Dr. Miglani strongly recommends that all patients over the age of eighteen receive an evaluation using the FDT Analyzer, which tests the health of your eyes and the visual pathways to your brain. This test can screen for many eye diseases such as Glaucoma, Multiple Sclerosis, and Brain Tumors in their early stages, which is not always detected in routine eye exams.
- We strong advise this test for anyone with a family member who suffers from glaucoma.
- It is especially important for those patients with a history of high blood pressure, headaches, migraines, floater or high spectacle prescription.
- This procedure only requires an additional 3 minutes of your time and a fee of $20.00. Please understand that while this test is optional for most, it represents preventive health for others. It may be required to "rule out" certain eye related diseases.

_____________ I would like my eye exam to include the **FDT Analyzer** test.

_____________ I would **NOT** like my eye exam to include the **FDT Analyzer** test.

Authorized Signature_____________________________ Date____________________________

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PATIENT ACKNOWLEDGEMENT

NOTICE OF PRIVACY POLICY

Our Notice of Privacy Practices describes in detail how your health information may be used and disclosed, and how you can access your information.

By signing below, you acknowledge that you have received a copy of the Notice of Privacy Practices of Sabal Eye Care.

____ ________________
Patient or legally authorized individual signature Date

____ ________________
Printed name if signed on behalf of the patient Relationship

CONSENT OF DISCLOSURE

FOR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

During the course of providing service to you, we create, receive and store health information that identifies you. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. It is often necessary to use and disclose your health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office. When it is appropriate and necessary, we provide the minimum necessary information to only those in need of your health care information.

When you sign this consent document, you acknowledge and authorize that we may disclose your health information for treatment, payment for our services, and to perform health care operations, that includes:

- The use and disclosure of your health information for treatment purposes, not only includes care and services provided here, but may be necessary for you to receive follow-up care from us or another health professional.
- The use and disclosure of your health information for the purposes of payment, including, but is not limited to , providing this information to your insurance company, third party, billing agent or other vendor for eligibility, determination of benefits, processing claims and receiving payment.
- We may have indirect treatment relationships with other organizations (such as laboratories and vendors) and may have to disclose personal health information for purposes of treatment, payment, or health care operations..
- That support personnel employed by this professional practice or any affiliated agencies, vendors or companies will have access to your health information.
- The payment of medical insurance benefits to Monroe Eye Care or other appointed agencies or parties who may accept assignment for services provided.

You have the right to restrict or revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health operations in reliance upon our ability to use or disclose your health information in accordance with this consent. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI).

ADVANCE BENEFITS NOTICE

MEDICARE AND OTHER HEALTH INSURANCE COMPANIES MAY OR MAY NOT COVER REFRACTION. IF THE CLAIM COMES BACK FROM YOUR INSURANCE COMPANY DENIED YOU WILL BE RESPONSIBLE FOR OUR FEE OF $45 TO COVER THE COST OF REFRACTION.

By signing below, you acknowledge that you have read and understand the above information and voluntarily consent to the statements herein.

____ ________________
Patient or legally authorized individual signature Date

____ ________________
Printed name if signed on behalf of patient Date