



# Eyecare Registration and History Form

526 Bloomfield Avenue, Suite 203, Caldwell, NJ 07006

## 1 Patient Information

Date: \_\_\_\_\_  
 Patient: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Sex:  M  F Age: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Single  Married  Widowed  
 Separated  Divorced  
 Patient SS#: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Location: \_\_\_\_\_

Name of Primary Doctor \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Town: \_\_\_\_\_  
 Pharmacy: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Town: \_\_\_\_\_

## 2 Insurance

Primary Insurance: \_\_\_\_\_  
 Subscriber: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_  
 Subscriber DOB: \_\_\_\_\_  
 Secondary Insurance: \_\_\_\_\_  
 Subscriber & DOB: \_\_\_\_\_

Do you need a referral to see Dr. Salzano?  Yes  No

Vision Plan:  Yes  No

Name of Plan: \_\_\_\_\_  
 Member's Name: \_\_\_\_\_  
 Member's DOB: \_\_\_\_\_  
 Last 4 digits of SS#: \_\_\_\_\_

### Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assigned directly to Dr. Salzano all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

**\*Vision Plans are for routine exams ONLY! Medical Plans are for problems, follow-ups or testing visits.**

## 3 Patient Contact Information

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Email: \_\_\_\_\_

### HIPAA PRIVACY AUTHORIZATION

Please list the names and relationships of the people with whom we can discuss your medical issues:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

If there are no changes from the last time you filled this form, initial here. \_\_\_\_\_

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# Eye Health History

Reason For Today's Visit:  Routine  Problem

Do you wear glasses:  Yes  No

Date of Last Exam: \_\_\_\_\_

All the time  Driving  Reading

Do you wear contacts:  Yes  No

Brand: \_\_\_\_\_

Base Curve: \_\_\_\_\_

(Right Eye) Power: \_\_\_\_\_ Sphere: \_\_\_\_\_ Cylinder: \_\_\_\_\_ Axis: \_\_\_\_\_ ADD: \_\_\_\_\_

(Left Eye) Power: \_\_\_\_\_ Sphere: \_\_\_\_\_ Cylinder: \_\_\_\_\_ Axis: \_\_\_\_\_ ADD: \_\_\_\_\_

Please mark "Yes" or "No" to indicate if you have had any of the following.

- |   |   |
|---|---|
| Bloodshot Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No             | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No                 |
| Blurred Vision- Distance <input type="checkbox"/> Yes <input type="checkbox"/> No   | Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| Blurred Vision - Near <input type="checkbox"/> Yes <input type="checkbox"/> No      | Itching Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| Burning Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No               | Light Sensitive <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No                  | Loss of Vision <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| Color Vision Poor <input type="checkbox"/> Yes <input type="checkbox"/> No          | Macular Degeneration <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| Crossed Eyes/Strabismus <input type="checkbox"/> Yes <input type="checkbox"/> No    | Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No       |
| Discharge from Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No        | Night Vision Poor <input type="checkbox"/> Yes <input type="checkbox"/> No        |
| Dizzy Spells <input type="checkbox"/> Yes <input type="checkbox"/> No               | Red Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No                 |
| Double Vision <input type="checkbox"/> Yes <input type="checkbox"/> No              | Retinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| Dry Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No                   | Seeing Halos <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| Eye Infection <input type="checkbox"/> Yes <input type="checkbox"/> No              | Seeing Flashes <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| Eye Injury <input type="checkbox"/> Yes <input type="checkbox"/> No                 | Temporary Loss of Vision <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Strain <input type="checkbox"/> Yes <input type="checkbox"/> No                 | Twitching Eyelid <input type="checkbox"/> Yes <input type="checkbox"/> No         |
| Eye Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No                | Vision Poor <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| Fainting Spells, Blackouts <input type="checkbox"/> Yes <input type="checkbox"/> No | Watering Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Floaters or Spots <input type="checkbox"/> Yes <input type="checkbox"/> No          |   |

### Family Eye History: Check all that apply

- Cataracts  Glaucoma  Macular Degeneration  Retinal Disease

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## Medications

## Allergies

List the medications you are currently taking, including eye drops:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List your allergies to medications or other

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## Consent to Use Dilating Drops

Dilating eye drops are used to enlarge the pupils, allowing Dr. Salzano to examine the inside of your eye. For many types of eye examinations, this is usually a requirement.

Dilating drops will usually cause blurred vision. Bright sunlight also can make it difficult to see. The length of time that your vision will be blurred, and the degree to which your eyesight is impaired, varies from patient to patient. Therefore, we strongly suggest you make arrangements for transportation. If you do choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself and others. In addition, adverse reactions, such as acute angle-closure glaucoma, may be triggered from the use of dilating drops. This is extremely rare and treatable with immediate medical attention.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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# Health History

Physician's Name: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Please mark "Yes" or "No" to indicate if you have had any of the following.

- |                        |                              |                             |                      |                              |                             |
|------------------------|------------------------------|-----------------------------|----------------------|------------------------------|-----------------------------|
| AIDS/HIV               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis (Type____) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lupus                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chemical Dependency    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shingles             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Skin Conditions      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Drug Sensitivity       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Emphysema              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Conditions   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Epilepsy               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hay Fever              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                      |                              |                             |
| Heart Condition        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                      |                              |                             |

If under 18

Birth History:

#Weeks \_\_\_\_\_ Complications \_\_\_\_\_

Tobacco use: \_\_\_\_\_ Alcohol Use: \_\_\_\_\_

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Eye Surgery: Type \_\_\_\_\_ Year \_\_\_\_\_

Surgery(Other): Type \_\_\_\_\_ Year \_\_\_\_\_

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## Medicare Authorization ATTENTION ALL MEDICARE PATIENTS

Medicare will **NOT** cover the cost of the **REFRACTION**.

*\*The refraction is the part of the exam that determines your prescription for either glasses or contacts.*

We do submit to secondary insurance however, we do not know how much they will cover, if any.

The most this service will cost you is **\$50**.

I understand that Medicare will not cover the cost of the refraction. I agree to be personally and fully responsible for payment. That is, I will pay personally either out of pocket or through any other insurance I have.

Check One:

Yes  I want receive these items or services.

No  I have decided not to receive these items or services.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_