

New Patient Registration Form

NJR NP F100

New Pt Packet V11.09.23

Patient Information

Patient Last Name	First Name		Middle Name	Maiden Name	
Address (Street or Box)			City	State	Zip Code
Home Phone Number	Cell Phone Number		Work Phone Number	E-Mail	
Social Security Number	Date of Birth	Assigned Sex at Birth ☐ Male ☐ Female	Pronouns ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Other: Please specify: _____		
Gender Identity (Check One) ☐ Identify as Male ☐ Identify as Female ☐ Gender Nonconforming/Non-binary ☐ Other (Please specify) _____ ☐ Choose not to disclose			Sexual Orientation (Check One) ☐ Lesbian/Gay/Homosexual ☐ Straight/Heterosexual ☐ Bisexual ☐ Something else, please describe _____ ☐ Don't Know ☐ Choose not to disclose		
Marital Status (Check One) ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Unknown			Race (Check One) ☐ American Indian or Alaska Native ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander ☐ Black or African American ☐ Asian ☐ White ☐ Other _____		
Ethnicity (Check One) ☐ Not Hispanic or Latino ☐ Hispanic or Latino			Employer Name	Employer Address	
Is patient residing in a Skilled Nursing Facility/ Rehabilitation Center? ☐ Yes ☐ No			If Yes, Name of Facility	City: Phone Number:	
Primary Care Physician Name			Phone Number		
Emergency Contact & Relationship		Phone Number	Referring Physician Name	Phone Number	

Responsible Party

Complete this section ONLY if Patient is a minor or has a Legal Guardian					
Responsible Party Last Name	First Name		Middle Name	E-Mail:	
Address (Street or PO Box)			City	State	Zip Code
Home Phone Number			Cell Phone Number	Work Phone Number	
Relationship to Patient ☐ Self ☐ Other (specify)			Date of Birth	Social Security Number	

Insurance and Subscriber Information

PRIMARY Insurance Company		Effective Date		SECONDARY Insurance Company		Effective Date	
Claims Mailing Address (Street or PO Box)				Claims Mailing Address (Street or PO Box)			
City	State	Zip Code		City	State	Zip Code	
Policy ID Number	Group ID Number			Policy ID Number	Group ID Number		
Subscriber Name (Policy Holder)	Date of Birth			Subscriber Name (Policy Holder)	Date of Birth		
Subscriber Social Security Number	Relationship to Patient			Subscriber Social Security Number	Relationship to Patient		
Subscriber Employer	Work Phone Number			Subscriber Employer	Work Phone Number		
Subscriber Employer Address (Street or PO Box)				Subscriber Employer Address (Street or PO Box)			
City	State	Zip Code		City	State	Zip Code	

Pharmacy

Preferred Pharmacy Name	Pharmacy Address	Pharmacy Phone Number
Mail-Order Pharmacy Name	Pharmacy Address	Pharmacy Phone Number

Vision Insurance (if applicable)

Vision Insurance and Subscriber Information

VISION Insurance Company		Effective Date
Claims Mailing Address (Street or PO Box)		
City	State	Zip Code
Policy ID Number	Group ID Number	
Subscriber Name (Policy Holder)	Date of Birth	
Subscriber Social Security Number	Relationship to Patient	
Subscriber Employer	Work Phone Number	
Subscriber Employer Address (Street or PO Box)		
City	State	Zip Code

Signature of Patient, Parent, or Legal Guardian

Date

Consent to Treat and Financial Responsibility

Consent to Treat NJR_NP_F101

I hereby authorize employees and agents of Associated Retinal Consultants, LLC ("ARC") dba NJRetina, an Affiliate of PRISM Vision Group, including physicians, physician assistants, nurse practitioners and other employees and staff members to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency.

Patient Name (Please PRINT)

Signature of Patient, Parent, or Legal Guardian

Date

Complete this section ONLY if patient is a minor or requires a Legal Guardian

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

Signature of Patient, Parent, or Legal Guardian

Date

Financial Responsibility NJR_NP_F102

I hereby authorize Associated Retinal Consultants, LLC ("ARC") dba NJRetina, an Affiliate of PRISM Vision Group, to apply for benefits on my behalf and for payment of medical benefits directly to ARC for services rendered. I request payments of Medicare, Medigap and/or any other insurance company to be made directly to ARC. Authorization is hereby granted to release information contained in the patients' medical record or the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical claim. I understand that I am financially responsible for all charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to ARC.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before services are rendered.

Patient Name (Please PRINT)

Signature of Patient, Parent, or Legal Guardian

Date

☐ **Yes**, I want Associated Retinal Consultants, LLC ("ARC") dba NJRetina, an Affiliate of PRISM Vision Group, to communicate my information with me through a secure system that is designed to keep my information safe.

My preferred method of communication regarding my medical conditions and/or appointment information is indicated below:

☐ Home Phone ☐ Cell Phone ☐ Email ☐ Mailed Letter ☐ Guardian

If the above method of communication is by phone, please do one of the following (**please check ONE**):

- ☐ Leave a message with detailed information.
☐ Leave a message with a call-back number only.

If the above method of communication is by email, please consider the privacy implications; for example, any other person that may have access to your e-mail address or any other person, such as your employer, that may have the right and/or ability to review all e-mail received at your work address.

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like us to call you at a different phone number for a specific test result or if you do not want to be contacted at all.

Keeping our patient's information private is important to us, and by default we will disclose information related to the patient's Billing Account and Medical Conditions only to the patient or legal guardian.

If you would like to add additional contacts, other than the patient or legal guardian, that Associated Retinal Consultants, LLC ("ARC") dba NJRetina, an Affiliate of PRISM Vision Group, is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you listed. If the End Date is left blank, then the duration of this authorization is indefinite unless otherwise revoked in writing.

Contact Name	Relationship to Patient	Contact Phone Number	End Date
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☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

Additional Notes: _____

Contact Name	Relationship to Patient	Contact Phone Number	End Date
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☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

Additional Notes: _____

Patient Name: _____

Date: ____/____/____

The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Associated Retinal Consultants, LLC ("ARC") dba NJRetina, an Affiliate of PRISM Vision Group, is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our practice, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations with our Practice. "Protected Health Information" is information about you, including demographic information, that may identify you as well as genetic information, and information that relates to your past, present or future physical or mental health or condition and related health care services.

On ____/____/____ I, _____, received a copy of this office's Notice of Privacy Practices.
(Today's Date) (Patient's Name)

Please Print Name

Signature

Date

* NJRetina's Notice of Privacy Practices can also be found on our website: <https://www.njretina.com>

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

This Acknowledgement Form will become part of your permanent medical record.

Medical Questionnaire / Eye History
NJR NP F108

Patient's Name:			Date / /		
What ocular problem brings you in?					
When was your last eye exam?	/ /		Eye Doctor		
What did your doctor tell you?					
YES NO					
Do you wear glasses for vision?					
Do you wear contact lenses?			If so, last time they were changed?		
Do you have Glaucoma?			If so, how is it being treated?		
Have you had cataract surgery?			If so, Which Eye?	Date of Surgery	Name of Surgeon
			Left Eye	/ /	
			Right Eye	/ /	
Have you had other surgery? <i>Please list details below</i>					

Medical History – Social History

Have you ever suffered from any of the following?

	YES	NO	Comment
Born Prematurely?			
History of Weight Loss, Fever?			
Headaches, Sinus, Tonsillectomy?			
Heart Condition?			
High Blood Pressure?			
Circulatory Problems?			
Lung Disease?			
Ulcers, Liver, Gall Bladder Disease?			
Do you Smoke?			
Do you Drink?			
Kidney, Bladder, Prostate Disease?			

	YES	NO	Comment
Joint Disease?			
Skin Disease or Breast Cancer?			
Stroke or Neurological Disease?			
History of Psychological Disease?			
Thyroid Disease?			
Diabetes?			
Date of Last Blood Sugar Results:			
Bleeding Disorder, Anemia?			
Aids or Infectious Disease?			
Cancer?			

List <u>ALL</u> Medications that you are presently taking, including any eye drops:		

List <u>ALL</u> Allergies Including Medications:

FAMILY HISTORY

Is there a family history of	YES	NO		
Cataracts?			Relative:	
Glaucoma?			Relative:	
Retinal Disease?			Relative:	
Diabetes?			Relative:	
Hypertension?			Relative:	
Anemia?			Relative:	
Other Eye or Systemic Disease?			Relative:	

Patient's Name:	Date / /
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Do you have any problems in the following areas? Please check all applicable

YES NO				YES NO			
GENERAL				GI / GU			
Fever				Vomiting			
Fatigue				Bloody Bowel Movement			
Weight Loss / Gain				Heartburn			
Frequent Colds				Loss of Appetite			
EYES				Difficulty with Urination			
Blurred Vision				Blood in Urine			
Double Vision				Frequent Urination			
Redness				Pain in Urination			
Sandy or Gritty Feeling				MUSCULOSKELETAL			
Blind Spots				Muscle Pain			
Floater				Joint Pain, Arthritis			
Flashes				INTEGUMENTARY			
Lazy Eye				Rash, Bruise Easily			
Itching / Burning				Breast Disease			
Excess Tearing				NEUROLOGICAL			
Glare / Light Sensitivity				Fainting, Frequent Headaches			
Eye Pain				Seizures			
Chronic Infection Eye / Lid				PSYCHIATRIC			
ENT: Ears, Nose & Throat				Depression			
Sinus Infection				Anxiety			
Cough				Psychiatric Problems			
Trouble Walking				ENDOCRINE			
Hoarseness				Excessive Thirst			
Loss of Hearing				Excessive Sweating			
Nose Bleeds				HEMATOLOGIC / LYMPHATIC			
HEART				Swollen Glands			
Chest Pain				ALLERGIC / IMMUNOLOGIC			
Irregular Heart Beat				Seasonal Allergies			
Pacemaker				Hay Fever			
Heart Murmur				OTHER			
Swollen Feet / Ankles				Pregnant			
Leg Cramps when Walking				Menopausal			
LUNGS				Vaginal Bleeding			
Wheezing, Shortness of Breath				Breast Lumps			
Coughing up Blood / Phlegm							

COMMENTS REGARDING ABOVE ANSWERS: (PLEASE PRINT)
