# 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**

**Preferred Method of Communication** NJR_NP_F104

☐ **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.**

**Approved HIPAA Contacts** NJR_NP_F105

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 |
|---|---|---|---|
| | | | |

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

**Additional Notes**: _____

| Contact Name | Relationship to Patient | Contact Phone Number | End Date |
|---|---|---|---|
| | | | |

☐ **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.***

njretina
an affiliate of PRISM Vision Group

## 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? *Please list details below* | | | | | |

### 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 ALL Medications that you are presently taking, including any eye drops: | List ALL 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: | |

# Medical History Questionnaire / Review of Symptoms

*NJR _NP_F109*

| Patient's Name: | Date / / |
|---|---|

**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 Vison | | | | Blood in Urine | | | |
| Double Vision | | | | Frequent Urination | | | |
| Redness | | | | Pain in Urination | | | |
| Sandy or Gritty Feeling | | | | **MUSCULOSKELETAL** | | | |
| Blind Spots | | | | Muscle Pain | | | |
| Floaters | | | | 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)**