Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)
Sex	Marital Status	Date of Birth (Age)	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address
Referred by	Primary Care Physician	Primary Care Physician Phone

Pharmacy	Pharmacy Phone	Pharmacy Address

Patient Employer/School Information

Employer / School	Occupation	Employer / School Phone

Employer / School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company		Plan
Plan Number	Group Number	Insured's Employer / School
Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number
Insured's Address	City	State / Zip
Insured's Social Security Number	Insured's Birthdate	

Secondary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer / School	Insured's Social Security Number
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

_____ _____

Signature of Patient or Authorized Guardian Date

Name _____ Gender _____ Age _____ Date of Appointment: _____

Visit Information

Who was your previous eye doctor?

Name _____

What brings you to the office today?

_____

_____

_____

_____

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

- ☐ Adhesive Tape
- ☐ Antibiotics
- ☐ Latex
- ☐ Barbiturates (Sleeping Pills)
- ☐ Aspirin
- ☐ Iodine
- ☐ Codeine
- ☐ Sulfa
- ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Eye Surgeries & Injuries

Have you ever had eye surgery or laser eye treatments?

☐ Yes ☐ No

Reason	Date

Eyes

Do you have any of the following?

- ☐ Blurred Vision
- ☐ Distorted Vision - Halos
- ☐ Loss of Vision
- ☐ Eye Burn
- ☐ Sandy Feeling in Eyes
- ☐ Mucous in Eyes
- ☐ Double Vision
- ☐ Eyes Sensitive to Light
- ☐ Redness in Eyes
- ☐ Dryness in Eyes
- ☐ Eyes Water / Tear
- ☐ Eye Itch
- ☐ Eye Pain
- ☐ Fluctuating Vision
- ☐ Stye
- ☐ Eyelid Infection
- ☐ Foreign Body Sensation in Eye
- ☐ Tired Eyes

Do you wear glasses?

☐ Yes ☐ No

Do you wear contacts?

☐ Yes ☐ No If yes, which brand? _____ **Power** _____

When was your last eye exam?

Date _____

Past Medical History

Have you ever had any of the following?

- ☐ AIDS / HIV
- ☐ Macular Degeneration
- ☐ Diabetes
- ☐ Arthritis
- ☐ Retinal Disorder
- ☐ Glaucoma
- ☐ Blindness
- ☐ Sjogren's Syndrome
- ☐ Cancer
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Cataracts
- ☐ Kidney Disorder
- ☐ Strabismus (Lazy Eye)
- ☐ Stroke
- ☐ Corneal Disease
- ☐ Thyroid Disease
- ☐ Lupus

Family History

Has anyone in your family ever had any of the following conditions?

- ☐ AIDS / HIV
- ☐ Macular Degeneration
- ☐ Diabetes
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Retinal Disorder
- ☐ Blindness
- ☐ Heart Disease
- ☐ Sjogren's Syndrome
- ☐ Cancer
- ☐ High Cholesterol
- ☐ Strabismus (Lazy Eye)
- ☐ Cataracts
- ☐ Kidney Disorder
- ☐ Stroke
- ☐ Corneal Disorder
- ☐ Lupus
- ☐ Thyroid Disease

Details:

_____

_____

_____

_____

Lifestyle Factors

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs / day _____

Do you smoke now?

☐ Yes ☐ No # packs / day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times / week _____

How much alcohol do you drink per week?

drinks / week _____

Do you drive?

☐ Yes ☐ No

Do you have difficulty driving?

☐ Yes ☐ No

Hospitalizations & Surgeries

Reason	Date

Patient Consent Form

Our Notice of Privacy Practices (January 2003 revision) provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in compliance with your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations, including appointment reminders by postcard or messages on an n answering machine.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This Consent allows the practice to disclose my information to the following people:
Spouse_____ Parents_____ Children_____
Other_____
Please print the names of the individuals.
X_____
Signature of Patient or representative.
Relationship to patient _____
Date:_____ Signed in front of Natalie Velazquez O.D.

Natalie Velazquez OD & Associates Inc.
222 Main Avenue, Passaic NJ 07055
Tel. 973-778-4662 Fax 973-778-3427
Lic# OA00602000 OM# 00063500

Appointment Cancelation Policy

It is our desire to provide the best care possible to all of our patients at all times. Furthermore, we strive to be on time for all scheduled appointments and avoid the long waiting times commonly occurring in other medical offices. To accomplish these objectives, we do not overbook appointments except in cases of an emergency. Unfortunately, this does mean that regularly scheduled appointments are a scarce commodity that must be accorded their proper value. When an appointment is canceled without adequate time to fill the time slot or when an individual fails to be present for an appointment without canceling that appointment, it interferes with the care available to all patients and impairs the proper functionality of the office. To avoid having to undertake changes that would radically change the way we deliver our medical care, the following policy is effective immediately and in all circumstances:

1) It is the responsibility of the patient or their legal guardian to be aware of the correct time and date of any scheduled appointment. A reminder phone call from our office is a courtesy and not a requirement for adherence to this policy.

2) It is the responsibility of the patient or their legal guardian to be aware of their Insurance Company requirements and to meet those requirements, including obtaining all required referrals, prior to receiving treatment for your scheduled appointment.

3) Appointments must be canceled within 24hrs of your scheduled appointment to avoid incurring a cancellation fee. Any patient canceling an appointment after the 24hr period prior to their appointment will be responsible for a **Cancellation Fee Of $50**, payable prior to receiving further treatment.

4) Patients failing to be present for a scheduled appointment without canceling will be assessed a **No-Show Fee Of $75**, payable prior to receiving further treatment.

5) Patients who fail to be present to any scheduled appointment without adequate notice of cancellation 2 or more appointments will need to leave a credit card on file as security prior to receiving further treatment. The credit card will be charged the corresponding fee if the scheduled appointment is not kept or canceled appropriately.

6) Patients who fail to be present for an appointment or who cancel an appointment without adequate notice on a total of 3 or more occasions may be discharged from the practice and asked to seek alternative medical care with another physician without further warning.

7) Patients who are present for an appointment without the required referral, may choose to be seen without the referral and pay for services via Cash or Credit/Debit **(No Checks Accepted)** at time of the visit or they will be assessed a No-Show Fee of $75.

I have fully read and understand these policies and have been given the opportunity to discuss them with the office staff or seek care with an alternative physician. I accept the conditions listed in this policy and will abide by the financial and logistical requirements they impose.

Printed Name (Patient/Legal Guardian/Parent) _____

Signature (Patient/Legal Guardian/Parent) _____ Date _____

Staff Wittiness Signature _____

Signature on File Form

• *RESPONSIBILITY STATEMENT* •

Your insurance is a method for you to receive reimbursement for fees you have paid to the optometrist for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them not with our office. It is your responsibility to pay in advance for the deductible, coinsurance, or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible in advance for your bill.

• *FINANCIAL RESPONSIBILITY* •

By signing this statement you agree to be financially responsible for all charges.

• *AUTHORIZATION TO RELEASE MEDICAL INFORMATION* •

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

Patient Signature_____ Date_____

Witness _____ Date_____