Pink Vision Associates

348 Ridge Rd
Lyndhurst, NJ 07071
201-438-8668

1562 Lemoine Ave.
Fort Lee, NJ 07024
201-461-7595

1068 Clinton Ave.
Irvington, NJ 07111
973-399-0909

Patient Information **Date: _____**

Last Name: _____First_____Middle Initial___ Nickname: _____

Address: _____ Date of Birth: _____ Age: _____

City _____ State _____ Zip _____ Gender: ❑ Male ❑ Female SS #:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance Policy Holder Name, Date of Birth and Relationship to patient:_____

Email Address: _____ Occupation: _____ Employer: _____

Computer Usage/Hobbies _____ Sports: _____Last Eye Exam: _____ Last Medical Exam: _____

Reason for your visit today: _____

Family Doctor _____ Office Phone: _____

Review of Medical Systems

Do you have any problems with the following medical systems? ❑ None Yes, please check all that apply in each section.

Eyes
❑Loss of Vision
❑Blurred Vision
❑Distorted Vision
❑Loss of Side Vision
❑Double Vision
❑Dry Eyes
❑Mucous Discharge
❑Redness
❑Itching
❑Burning
❑Foreign Body Sensation
❑Excess Tearing
❑Glare/ Light Sensitivity
❑Eye Pain
❑Styes
❑Flashes
❑Floaters
❑Lazy eye/ eye turn
❑Glaucoma
❑Cataracts
❑Macular Degeneration

Respiratory
❑ Asthma
❑ Chronic Bronchitis
❑ Emphysema
❑ Sleep Apnea

Ears, Nose, Throat
❑ Hay Fever
❑ Sinus Congestion
❑ Dry Throat/Mouth
❑ Post-Nasal Drip
❑ Chronic Cough
❑Ringing in the Ears
❑Ear Pain or Infection
❑Hearing Aids
❑Deaf

Vascular/Cardiovascular
❑ Diabetes
How many years? ___
Last Blood Sugar ___
Controlled ❑ Yes ❑ No
Hab1C ___
❑ Heart Disease
❑ High Blood Pressure
How many years? __
Controlled ❑ Yes ❑ No
❑ High Cholesterol

Gastrointestinal
❑ Diarrhea
❑ Constipation

Genitourinary
❑ Gonads/Kidneys/Bladder

Bones/Joints/Muscles
❑ Rheumatoid Arthritis
❑ Muscle Pain/Weakness
❑ Joint Pain

Lymphatic/Hematological
❑ Anemia
❑ Bleeding Problems

Endocrine
❑Thyroid

Psychiatric
❑ Depression
❑ Anxiety/Panic Disorder
❑ Post-Traumatic Stress

Neurological
❑ Headache
❑Migraines
❑ Seizures/Epilepsy

Constitutional
❑ Fever
❑ Weight Gain/Loss

Integumentary
❑ Skin

Other:

Family Medical History
❑ **No Family Medical Conditions**
Is there any family medical history of any of the following? (If yes, please list their relationship to you)

	Relationship to you
❑ Blindness	_____
❑ Cataracts	_____
❑ Glaucoma	_____
❑ Crossed eyes	_____
❑ Diabetes	_____
❑ Heart Disease	_____
❑ High Blood Pressure	_____
❑ High Cholesterol	_____
❑ Macular Degeneration	_____
❑ Kidney Disease	_____
❑ Retinal Detachment	_____
❑ Arthritis	_____
❑ Cancer	_____
❑ Lupus	_____
❑ Thyroid Disease	_____

❑ Other (please explain)

Have you ever been exposed to or infected with:
❑Gonorrhea ❑Hepatitis ❑Syphilis
❑ Herpes ❑ HIV/AIDS

Do you have any allergies to medication: ❑ None ❑ Penicillin ❑ Sulfa drugs ❑ Other: _____
Do you take any prescription or non-prescription medicines regularly? ❑ Yes ❑ No
If yes, please list all medicines:_____
_____

Are you, or could you be pregnant? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No
Are you interested in being evaluated for contact lenses today? ❑ Yes ❑ No
Brand and Power of your current contacts: _____How old is your current pair of lenses? _____ weeks

Social History
❑ I prefer to discuss my Social History directly with my Doctor. Do you use any of the following: ❑ **None**
Alcohol ❑ Yes ❑ No Tobacco ❑ Yes ❑ No Illegal Drugs ❑ Yes ❑ No

FEES ARE NOT REFUNDABLE.
PAYMENT IS DUE IN FULL AT TIME OF SERVICE.

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Acknowledgment of Privacy and Voluntary Consent Form

In providing services to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this information in order to treat you and conduct healthcare operations involving our office. The Notice of Privacy Practices posted in our office describes these uses and disclosures in detail. Please refer to this notice any time prior to signing this consent form. Copies are available for your personal documents.

I have read this Receipt and Consent form and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare options.

Print Patient's name _____

Sign _____ Date _____

Print name and relationship if signing on behalf of this patient:

_____

Screening Fundus Photography

Fundus photographs are visual records or a picture of the back of the eye which document the current appearance of a patient's retina. One picture is worth, in this instance, a thousand words in the doctor's notes. They allow the physician to further study a patient's retina, to identify retinal changes on follow-up, or to review a patient's retinal findings from year to year. The objective of this more thorough test is to document early signs of life or sight-threatening eye conditions such as glaucoma, tumor of the eye, optic nerve disease, retinal detachment, signs of diabetic retinopathy or hypertensive retinopathy.

The screening fundus photograph is $15 in addition to the cost of your exam, if you would like to get it done. This test is not covered by insurance unless there is an appropriate diagnosis, in which case a full resolution photo would be taken.

I would like to have fundus photography today. Yes No

Sign _____ Date_____

Insurance Information Release

When making a third party claim, I authorize the release of my medical information to process my third party claim. I authorize Pink Vision Associates to file complaints on my behalf if my third party carrier does not properly handle my claim. I authorize the release of any information pertinent to my case to any third party, adjuster or attorney involved in resolving the financial status of my account. I authorize my third party plan to pay Pink Vision Associates directly. If my plan does not pay this claim, I agree to be responsible for the payment of these professional services.

Sign _____ Date _____

Print name and relationship if signing on behalf of this patient:

_____