Name_____

Address_____

City/State_____Zip Code_____

Phone#_____
(Please list any additional numbers where you can be reached – home, work, cell)

 Sex: Male Female **Date of Birth_____Age_____**

(Circle One)

 Minor Single Married Widowed Separated Divorced

Who may we thank for referring you?_____

Primary Care Doctor_____
(Pediatrician/ Family Physician)

Address/ Phone # _____

FOR MINORS ONLY –

Mother's/Guardian's Name_____

Address (**if different than patient**)_____

Father's/Guardian's Name_____

Address (**if different than patient**)_____

FINANCIAL INFORMATION

Please read carefully and check one:

_____**Self Pay** for patients who do not have vision coverage and/or an insurance with which we do not participate. If self pay, we do not need any additional insurance information.

_____**Insurance information below** – to the best of my knowledge, this visit should be covered by the insurance company listed. Any denied claims will become the patient's (parent/guardian's) responsibility.

PRIMARY INSURANCE INFORMATION

Insurance Company_____

Subscriber_____Subscriber's Date of Birth_____
(**Name of person who is the policyholder**)

Relationhip to Patient (circle one): **SELF SPOUSE FATHER MOTHER GUARDIAN**

Employer_____

ADDITIONAL INSURANCE INFORMATION

Insurance Company_____

Subscriber_____

Relationship to Patient_____Birth Date of Subscriber_____

Employer_____

Please read each statement carefully. If you have any questions, please ask.

WE DO NOT PARTICIPATE WITH VISION PLANS

- Ophthalmic/Optometric services are provided for **MEDICAL** care, as well as, **VISION** care.

  MEDICAL – eye disease, eye injury, eye infection, medical complaints (exp. redness, discharge, double vision), or a pediatric medical problem with the eyes such as amblyopia (lazy eye) or strabismus (crossed eyes).
  VISION – difficulty seeing eye chart with no medical cause, blurred vision with no medical cause, myopia, hyperopia, astigmatism, at times, headaches, or simply not having any complaints.

  Your plan may only consider payment for MEDICAL care and MAY NOT include VISION care. This includes exams referred by your primary doctors, pediatricians, and school nurses. If you are unsure if your exam is for MEDICAL or VISION, please ask.

  Your insurance company may state that you are ONLY covered for a VISION SCREENING. A VISION SCREENING is not a CONSULT/ INTERMEDIATE/ COMPREHENSIVE EYE EXAM.

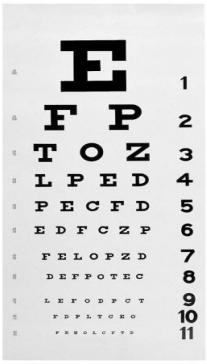
- *We **DO NOT** participate with **VISION** plans*. Most insurance companies now offer a separate vision plan that we DO NOT participate with. While your insurance company may state you have VISION, many fail to include the that it is with a separate VISION plan. We ***will not*** submit claims to your VISION plan.
- The patient must provide us with a valid insurance care and valid referrals at the time of the visit. Any unpaid visits because insurance cards and/or valid referrals were not provided, will become the patient's (parent/guardian) responsibility.
- With most insurance plans, referrals are not valid for vision care unless you are being referred for a medical condition or disease.
- Many insurance plans now have a deductible to meet before your insurance will make payment. You are responsible for any deductibles applied towards your office visits.
- A **REFRACTION** is done to determine whether an initial prescription needs to be given or an existing prescription needs to be changed. This part of the exam is billed as a separate procedure with an additional charge. If the REFRACTION is not covered by your insurance company, the patient (parent/guardian) becomes responsible for payment.
- If a check is returned to the office for any reason, there will be an additional $25 charge.

If you have any questions, please ask. Please do not call our office, after your visit was denied or you receive a statement, and state "NO ONE TOLD ME."

FALSIFYING A DIAGNOSIS IS INSURANCE FRAUD. We will not falsify a diagnosis to meet your medical insurance plan requirements. **Please DO NOT ask us**. If you have any medical concerns, please make sure you express these concerns **at the time of the visit.**

By signing below, I acknowledge that I have read the above statements. I acknowledge I am financially responsible for all charges including any copays, deductibles, non-covered/denied services, or any charges not paid by my insurance company. I hereby assign all insurance benefits to which I am entitled, including Medicare and/or other insurance or plans to Ronald Minzter MD PC. I authorize Ronald Minzter MD PC to release all information necessary to secure payment of benefits.
I authorize this signature on all insurance claims.

Signature Relationship to Patient Date



Ronald Minzter, MD
Pediatric Ophthalmology & Adult Strabismus
Edward Kulback, OD
Optometric Physicians
Comprehensive Family Eye Care

495 Iron Bridge Road Suites 2 & 6 Freehold, NJ 07728
Tel: 732. 577. 5558 Fax: 732. 577. 5559

PATIENT NAME_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ I have read this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

PATIENT PRIVACY QUESTIONNAIRE:

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and diagnosis.

   _____

   _____

2. Please print any additional phone numbers where we may contact you about your appointments or other health care information other than your home number.

   _____

   _____ (INITIAL) "I am fully aware that a cell phone is not a secure and private line.

3. Can messages (e.g. appointment reminders) be left on your telephone answering machine or voicemail?

   _____ YES _____ NO

4. Can we send RECALLS or REMINDERS on a post – card to your home address?

   _____ YES _____NO

_____

Signature of Patient **Date**

_____

Print Name of Patient **Date**

Patient Name_____Date_____

EYE HISTORY Do you or does anyone in your immediate family have a history of the following? **CIRCLE ONE**

Cataracts		NO	SELF	FAMILY _____ _____
Glaucoma	NO	SELF	FAMILY	_____
Crossed or Lazy Eyes	NO	SELF	FAMILY	_____
Blindness		NO	SELF	FAMILY_____
Retinal Detachment	NO	SELF	FAMILY	_____
Macular Degeneration	NO	SELF	FAMILY	_____

- Have you ever had any eye injuries or surgeries? **YES** **NO**

If yes, please explain_____

- List any medications you are currently taking_____

_____

- List any drug allergies you may have_____

Your overall health affects the health of your eyes. Many systemic conditions can have ocular effects. To ensure proper care, our docto companies require a health and vision history from our patients as part of an eye exam.

HEALTH HISTORY Do **CURRENTLY** have any of the following?

General/Constitutional(fever, heat stroke, weight loss or gain, unusually tired)	NO	YES _____
Psychiatric (anxiety, depression, insomnia)	NO	YES_____
Ears, Nose, Throat, Mouth (hard of hearing, ear ache, cough, dry mouth)	NO	YES_____
Respiratory (Asthma, Emphysema)	NO	YES_____
Genitourinary (painful/ frequent urination, impotence, jaundice)	NO	YES_____
Hemotologic/ Lymphatic (bleeding, anemia, cholesterol)	NO	YES_____
Allergic/ Immunological (sneezing, hives, redness, itching, Lupus)	NO	YES_____
Integumentary (skin – pimples, warts, rash, growths)	NO	YES_____
Musculoskeletal (joint pain, stiffness, cramps, arthritis, swelling)	NO	YES_____
Cardiovascular (high blood pressure, racing pulse)	NO	YES_____
Endocrine (diabetes, hypothyroid)	NO	YES_____
Gastrointestinal (stomach upset, diarrhea, constipation, ulcer)	NO	YES_____
Neurological (numbness, headache, seizures, paralysis)	NO	YES_____

- List all major illnesses or injuries you **have had**_____

_____

- General surgery? **NO** **YES** If yes, What/When_____

_____

FEMALES (of child bearing age) Are you currently pregnant? YES NO Are you currently nursing? YES NO Not Applicable

Adults: Tobacco use: YES NO If yes, how much? Occasional 1/2pk/day 1pk/day 1+pk/day

Alcohol use: YES NO If yes, how much? Occasional 1/day 2-3/day 4+/day

Current occupation_____List any hobbies/activities you enjoy_____

Minors: If a student, current grade_____ List any hobbies/activities you enjoy_____