



## **EYE CARE ASSOCIATES OF NEW JERSEY, P.A.**

**ADAM S. FRIEND, M.D.**

**JAMES KIRSZROT, M.D.**

**JYOTHIS A. ABRAHAM-COHEN, O.D., M.S.**

Dear \_\_\_\_\_,

We appreciate your selection of our office for your complete eye care. Your appointment is on \_\_\_\_\_ at \_\_\_\_\_ with Dr. \_\_\_\_\_. We would appreciate it if you could arrive 15 minutes early to allow time to prepare your records. First visits usually take approximately one and a half hours. Dilation of your eyes will be required for most examinations. Since the effect of this procedure can take several hours to wear off, you may want to arrange for transportation following the appointment. Please bring sunglasses during the daylight hours because these drops can make your eyes sensitive to light.

We have enclosed a patient registration form and medical history questionnaire. Please complete these forms at home and bring them with you to your appointment. Please bring a list of any medications and eye drops that you are currently using along with your eyeglasses or contact lenses. Be sure you have all of your insurance cards and photo identification with you when you come to the office.

Our practice accepts most major insurances. We will bill participating insurances for the visit. Applicable co-payments, deductibles, and referrals as required by your insurance plan are due at the time of your visit. We accept cash, checks, Master Card, Visa and Discover Card for your convenience.

A parent or legal guardian must accompany a patient under the age of 18.

We look forward to seeing you. If you should have any questions, please contact us at (201)797-5100.

Sincerely,

Adam S. Friend, M.D.

James Kirsztrot, M.D.

Jyothis A. Cohen, O.D., M.S.

One Broadway, Suite 404 • Elmwood Park, NJ 07407

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**EYE CARE ASSOCIATES OF NEW JERSEY, PA**  
 One Broadway Suite 404 Elmwood Park, NJ 07407 (201) 797-5100 FAX (201) 797-4160

**PATIENT REGISTRATION**

Welcome to our office. In order to serve you properly, we will need the following information:  
**(Please Print In Ink)**

Patient First Name	Middle Initial	Last Name	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth	Pharmacy/Location
Mailing Address	City	State	Zip	Age	Social Security #
Home Phone:	Cell Phone:		Email address:		Preferred contact: Email or Reg Mail
Name of Employer	Address		Occupation	Business Phone	
Name of Spouse/Significant Other/Parent	Date of Birth	Social Security #	Marital Status (circle) S M W D		Alternate Phone
Name of Spouse/Significant Other/Parent's Employer / Address	Business Phone		Relationship to Patient		
Name of Person Responsible For This Account					
<b>Reason for visit</b> <input type="checkbox"/> Medical Eye Exam OR <input type="checkbox"/> Vision Exam (explain)					
Person to contact in case of emergency			Relationship to patient	Phone	
<b>Primary Insurance Coverage (referral required <input type="checkbox"/> Yes <input type="checkbox"/> No please initial )</b>					
Primary Insurance Company		Address			
Subscriber Name	Subscriber birth date	Policy #	Group #		
Is this insurance through your employer? Yes <input type="checkbox"/> No <input type="checkbox"/>		Patient's relationship to insured Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
<b>Secondary Insurance Coverage</b>					
Secondary Insurance Company		Address			
Subscriber Name	Subscriber birth date	Policy #	Group #		
Is this insurance through your employer? Yes <input type="checkbox"/> No <input type="checkbox"/>		Patient's relationship to insured Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
<b>DO YOU HAVE VISION INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No</b>					
<b>(VSP- VISION SERVICE PLAN OR LOCAL 164 – IBEW MEMBER PLEASE FILL-IN BELOW)</b>					
Subscriber name		SS #	DOB:		
<b>X</b>	Patient Signature		Date		

**BILLING AND OFFICE POLICY**  
**ASSIGNMENT OF BENEFITS**

I \_\_\_\_\_, have requested treatment from Eye Care Associates of New Jersey, PA Please read and then sign in the space provided. Should you have further questions our staff will gladly assist you.

**PATIENTS WITH INSURANCE**

It is your responsibility to provide your insurance information. Without complete insurance information Eye Care Associates of New Jersey, PA cannot bill for services. Proof of insurance is required at the time of service. Insurance is a contract between you and your insurance company. As a courtesy to you, we will file your claim but you are ultimately responsible for all charges regardless of what your insurance does or does not pay. Your co-pay and any deductible not satisfied will be collected at the time of service. **A \$10 service charge will be added to your account if your co-pay, Medicare 20% co-insurance, or refraction fee are not paid at the time of service.**

**PATIENTS WITHOUT INSURANCE**

All charges incurred at the time of service must be paid in full at the end of each appointment. If you are unable to pay in full at the time of service, arrangements must be made in advance with the office manager.

**DELINQUENT ACCOUNTS**

Outstanding accounts in excess of 90 days will be forwarded to IC Systems, Inc for collection proceedings. Should circumstances prevent you from paying your account in a timely manner prior to commencement of collection activity please contact our office to make other arrangements for payment. Patients with delinquent accounts may be permanently discharged from our practice. **Returned checks for non-sufficient funds (NSF) will incur a \$30.00 NSF fee.**

**VISION EXAM**

These are examinations for diagnosis of vision problems or correction of vision prescriptions. A vision exam determines if vision can be improved with glasses or contact lenses. It is a basic screening exam, which may include refraction and dilation. **These are for measurement purposes only and are not intended to diagnose or treat diseases of the eye.**

**MEDICAL EXAM**

These are examinations for diagnosis of diseases that manifest with ocular symptoms. If glasses or contact lenses cannot improve vision, often the cause is related to an underlying medical condition. This type of exam is a detailed analysis of all parts of the eye including a dilated exam of the peripheral retina and vitreous for pathology causing loss of vision.

**REFRACTION FEE**

Refraction is the optical determination of the best possible eye vision. It is needed to determine if any medical, optical, or surgical treatment may be indicated. It is **NOT** a covered service by most insurance plans. Our office fee for refraction is thirty-five dollars (\$35), is collected at the time of service, and is in addition to any co-payment.

I have received a copy of the privacy policies for Eye Care Associates of New Jersey, PA.

I assign all insurance benefits (including Medicare, if applicable) directly to Eye Care Associates of New Jersey, PA and authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. In Medicare assigned cases, the physician, or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

**X**

**Patient, Parent or Guardian Signature (if child is under 18)** \_\_\_\_\_

**Date** \_\_\_\_\_

Revised 08/26/2009

The above signatures / authorizations are valid for the duration of the patient's care unless retracted in writing by the patient.

# MEDICAL HISTORY QUESTIONNAIRE

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Date of last eye exam \_\_\_\_\_

List any medications you currently take (prescription and over-the-counter): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List any allergies to medication: \_\_\_\_\_  
 \_\_\_\_\_

List all major illnesses (glaucoma, diabetes, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List any surgeries you have had (cataract, tonsillectomy, appendectomy): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you <b>currently</b> have any problems in the following area?:				
	If YES, please provide information.	YES	NO	Details
<b>EYES</b>				
Loss of vision				
Blurred vision				
Fluctuating vision				
Distorted vision (halos)				
Glare or light sensitivity				
Loss of side vision				
Double vision				
Dryness				
Mucous discharge				
Redness				
Sandy or gritty feeling				
Itching				
Burning				
Foreign body sensation				
Excess tearing or watering				
Eye pain or soreness				
Infection of eye or lid				
Tired eyes				
Crossed eyes, lazy eye				
Drooping eyelid				

**REVIEW OF SYSTEMS**  
Do you currently have any of the following problems?

If YES, please explain.

1. <b>Constitutional</b> (fever, weight loss, other)	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. <b>Ear / nose / mouth / throat</b> (hearing loss, sinus problems, sore throat)	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. <b>Cardiovascular</b> (heart problems, chest pain, irregular heart beat)	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. <b>Respiratory</b> (asthma, shortness of breath, wheezing, coughing)	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. <b>Gastrointestinal</b> (heartburn, abd. pain, diarrhea, vomiting)	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. <b>Genitourinary</b> (urinary problems, blood in urine)	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. <b>Integumentary</b> (skin rashes, excessive dryness)	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. <b>Musculoskeletal</b> (muscle aches, joint pain, swollen joints)	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. <b>Neurological</b> (numbness, weakness, headaches, paralysis)	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. <b>Hematologic/Lymphatic</b> (blood disorders, leukemia)	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. <b>Allergic/Immunologic</b> (hay fever, allergies)	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. <b>Endocrine</b> (thyroid problems)	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. <b>Psychiatric</b> (depression, anxiety)	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Family and social history:** Do any medical or eye diseases run in your family. If YES, Please note relationship to patient.

Glaucoma \_\_\_\_\_

Diabetes \_\_\_\_\_

High blood pressure \_\_\_\_\_

Macular degeneration \_\_\_\_\_

Other \_\_\_\_\_

Do you smoke? If YES, how much?  Yes  No

How much: \_\_\_\_\_

Drink alcohol? If YES, how much?  Yes  No

How much: \_\_\_\_\_

Comments: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_