

Patient Referral to:



Retina Vitreous Center

An affiliate of Associated Retinal Consultants, L.L.C.

Practice Limited to Consultation and Surgery of the Retina, Vitreous, Macula and Diabetic Retinopathy

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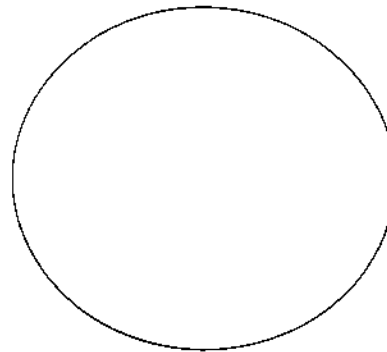
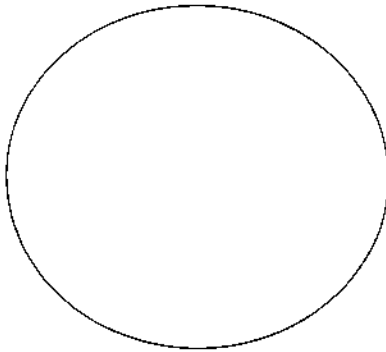
Patient's Name: _____ Exam Date _____

Referring Physician: _____ Diagnosis: _____

Ocular History: _____

OD

OS



Primary Eye:

OD

OS

OU

Other Instructions/Present History:

INSTRUCTIONS TO PATIENT:

Please bring this form with you to our office.

Your eyes will be dilated and we advise that you have a driver.

You will be in our office a minimum of two hours. If you need a referral from your insurance plan, please be sure to obtain one prior to your visit.

Please bring your glasses - Both distance and reading and a pair of sun glasses.

If you are a diabetic, please bring a snack.

If you do not speak English, please bring a translator.

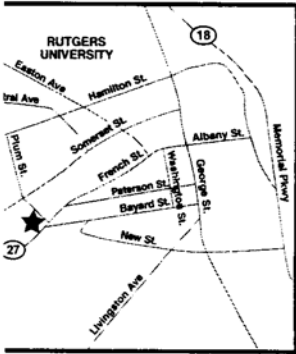
PHONE NUMBERS AND MAPS ARE ON THE REVERSE SIDE OF THIS PAGE

www.retinavitreouscenter.com

Retina Vitreous Center Office Locations

(See our website for detailed Google directions)

www.retinavitreouscenter.com



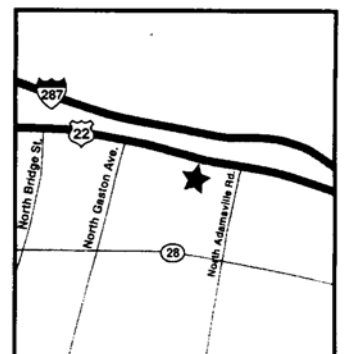
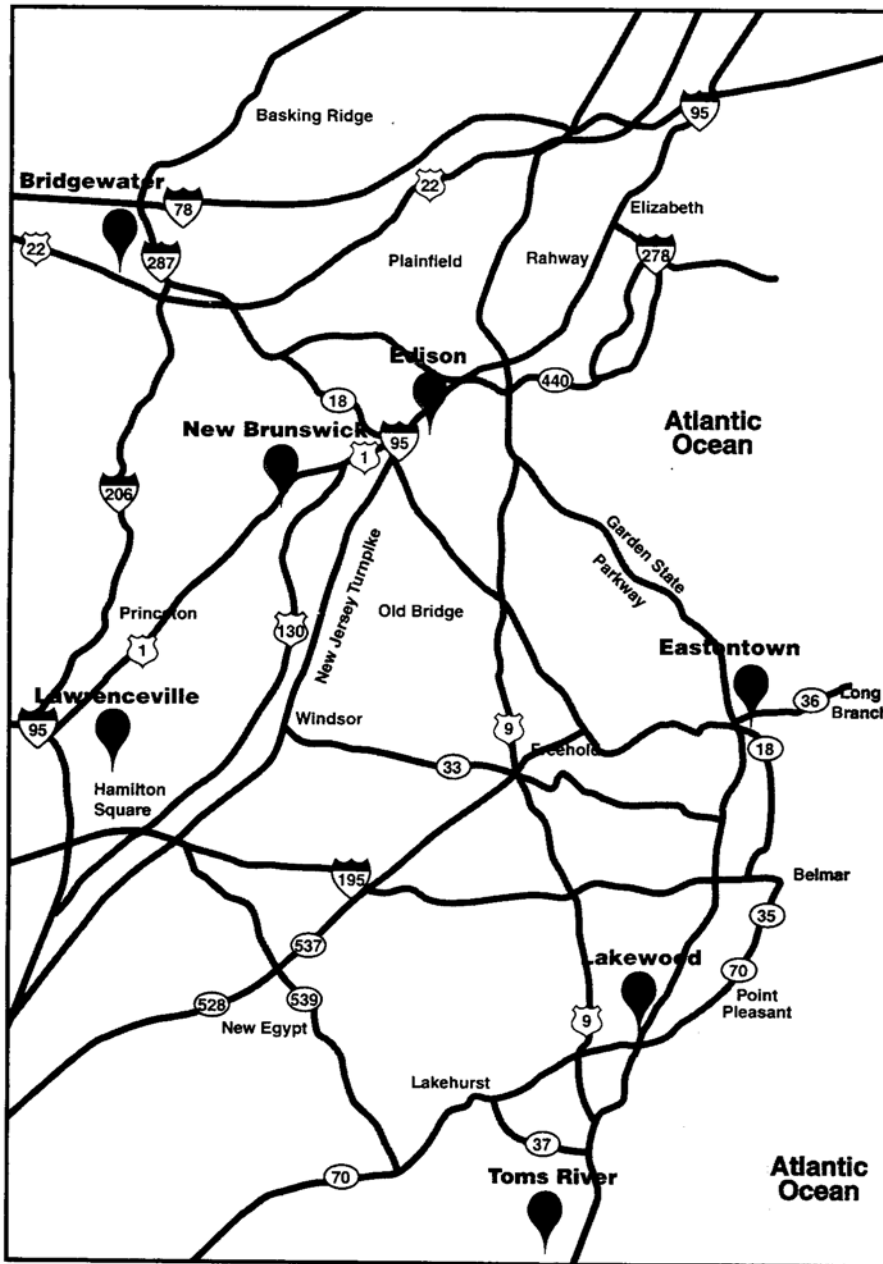
10 Plum Street
Suite 600
New Brunswick, NJ 08901
Tel: (732) 220-1600
Fax: (732) 220-1603



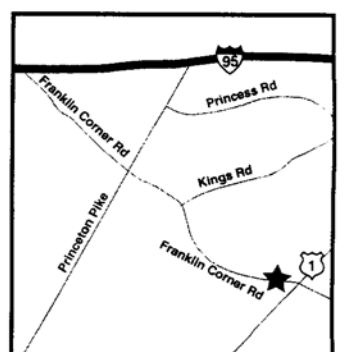
Medi-Plex
98 James Street, Ste. 310
Edison, NJ 08820
Tel: (732) 906-1887
Fax: (732) 906-1883



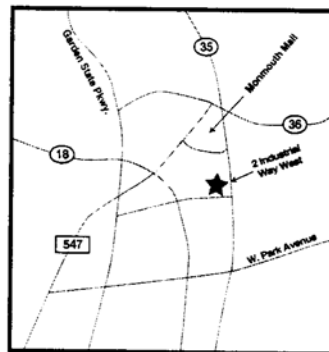
Northern Ocean Prof. Plaza
525 Route 70 West
Lakewood, NJ 08701
Tel: (732) 363-2396
Fax: (732) 363-0403



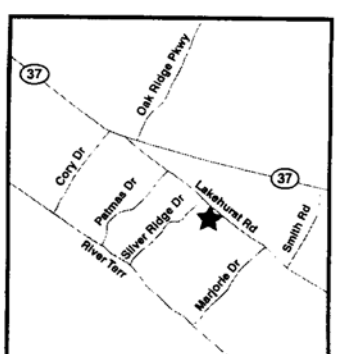
Greymark Building
1200 Route 22 East, 1st Fl.
Bridgewater, NJ 08807
Tel: (908) 218-4303
Fax: (908) 218-4307



140 Franklin Corner Road
Lawrenceville, NJ 08648
Tel: (609) 896-3655
Fax: (609) 895-0853



Meridian Center I
2 Industrial Way West, 3rd Floor
Eatontown, NJ 07724
Tel: (732) 389-2333
Fax: (732) 389-2788



Pyramid Center
530 Lakehurst Road, Ste. 305
Toms River, NJ 08755
Tel: (732) 797-3883
Fax: (732) 797-3866



PATIENT REGISTRATION FORM

First Name		MI	Last Name	
Home Address				Apt#
City		State	Zip Code	
Date of Birth		Gender <input type="checkbox"/> M <input type="checkbox"/> F		SS#
Home Phone#		Work#		Cell #
Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W		E-mail Address		Driver's License#
Patient Employer / Occupation (indicate if student)				
Financially responsible persons address (if different from patient)				
Is patient residing in Skilled Nursing Facility? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, name and address of facility				Phone
Emergency Contact Name		Relationship		Phone
Referring Physician Name/Address				Phone
Primary Care Physician Name/Address				Phone

INSURANCE INFORMATION:

Primary Insurance				
ID#	Group #	Effective date	Subscriber Employer	
Policy Holder	Subscriber DOB		Relationship to Subscriber	Subscriber SS#
Address:			Phone#	
Secondary Insurance				
ID #	Group #	Effective Date	Subscriber Employer	
Policy Holder	Subscriber DOB		Relationship to Subscriber	Subscriber SS#
Address:			Phone#	

FINANCIAL POLICY STATEMENT

Welcome to Retina Vitreous Center, we are pleased that you have chosen our practice for your medical care. We are committed to providing you with the highest quality services available. Please read and sign the following policy. If we are contracted with your insurance company we will accept assignment. All co-pays, co-insurance and deductibles are due and payable at time of service. Failure to provide necessary referrals or current accurate billing information will result in all charges for services the sole responsibility of the patient/responsible party. You are expected to understand your benefits coverage and financial responsibility. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payment at time of service. You will be responsible for any balances not covered by your insurance. Should your account be sent to a third party collector, you agree to pay an additional 30% of the balance or \$50, whichever is greater. A return check fee of \$35 will be assessed if your check is returned by your bank.

Patient Signature _____ **Date** _____

PATIENT AUTHORIZATION

I hereby authorize ASSOCIATED RETINAL CONSULTANTS, LLC to apply for benefits on my behalf for services rendered. I request payments from Medicare, Medigap, and or any other insurance company be made directly to ASSOCIATED RETINAL CONSULTANTS, LLC. I certify that the information I have provided on this form is correct. I authorize the release of any necessary information for this or any related claim to the above named carrier or in case of Medicare part B benefits.

Patient Signature _____ **Date** _____

Social History

Name: _____ Date: _____

Marital Status: 0 Single 0 Married 0 Divorced 0 Widowed 0 Other

Present Occupation: _____

What type of work did you perform in the past: _____

Any history of drug abuse: YES _____ NO _____ If yes, indicate what: _____

Do you drink alcohol: YES _____ NO _____ If yes, how many glasses a day: _____

Do you presently smoke: YES _____ NO _____ If yes, how many packs a day: _____

If you quit, how long ago: _____ If yes, for how many years: _____

Educational level (Please check highest)

High school graduate College Graduate Post-graduate degree Other

Have you ever had sexual contact with a person who may have been exposed to or infected with

the AIDS virus: YES _____ NO _____

Have you ever had any of the following transmitted diseases:

Gonorrhea YES _____ NO _____ Syphilis YES _____ NO _____

AIDS YES _____ NO _____ Hepatitis YES _____ NO _____

HIV positive YES _____ NO _____

Have you had a blood transfusion: YES _____ NO _____ If yes, when: _____

History Reviewed: _____

Date: _____

Physicians signature: _____

Medical History Questionnaire (ROS)

Name: _____ Date: _____

Do you have any problems in the following areas? (Check Yes or No)

	YES	NO		YES	NO
General:			GI / GU:		
Fever	_____	_____	Vomiting	_____	_____
Fatigue	_____	_____	Bloody bowel movements	_____	_____
Weight loss or gain	_____	_____	Heartburn	_____	_____
Frequent colds	_____	_____	Loss of appetite	_____	_____
EYES:			Difficulty with urination	_____	_____
Blurred vision	_____	_____	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 sensitive	_____	_____	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 breath	_____	_____	Breast lumps	_____	_____
Coughing up blood / phlegm	_____	_____			

COMMENTS REGARDING ABOVE ANSWERS (PLEASE PRINT):

Medical History Questionnaire (PFSH)

Name: _____ Date: _____

History: For yourself and <i>each</i> member of your family, check all that apply.	<u>PATIENT</u>		<u>FAMILY MEMBERS</u>					
	YOUR HISTORY	DURATION	<i>Father</i>	<i>Mother</i>	<i>Brother / Sister</i>	<i>Child</i>	<i>Child</i>	<i>Child</i>
Diabetes								
High Blood Pressure								
Heart Disease								
Kidney Disease								
AIDS								
Hepatitis								
Cancer or Tumor								
Respiratory (Lungs)								
Blood Diseases								
Stomach - Ulcer								
Arthritis (Joints)								
Stroke								
Neurologic (Brain)								
Cataract								
Retinal Detachment								
Glaucoma								
Macular Degeneration								
Other								

MEDICATIONS: (LIST)

ALLERGIES & REACTIONS: (LIST)

If you have had any SURGERY in the past, please list:

Type of surgery	Year