Welcome to Our Practice

Patient Registration

Date: _____

Patient's Last Name _____ First _____ M.I. _____
Address _____
City _____ State _____ Zip _____
Date of Birth _____ Age _____ Sex ____M ____F
Social Security # _____ Cell Phone # _____
Home Phone_____ E-mail _____

Family Physician_____ Telephone _____
Address _____
Eye Doctor_____ Telephone_____
Address _____
Local Pharmacy_____Telephone_____
Address_____

Patient's Employer _____
Work Address _____
Work Phone _____
Occupation _____Full / Part Time _____ Student _____
Is your condition or injury work related? No ____Yes ____ Date of injury _____

If the patient is a minor:

Mothers Name _____
DOB_____Social Security # _____
Address If Different:

_____
_____
Home phone_____
Employer_____
Address_____
Work Phone_____

Fathers Name_____
DOB _____Social Security_____
Address if Differrent:

_____
_____
Home Phone_____
Employer_____
Address_____
Work Phone_____

Person Responsible for Payment (If patient is a minor, parent or guardian)

The person who requests treatment is responsible for all fees for services rendered.

Name _____Relationship_____

Primary Insurance Information (we would like to photocopy your card).

Name of Ins Company _____Ins Phone Number_____
ID or Policy Number _____
Group Number or Plan Number _____
Address to send claim forms _____
City _____State _____ Zip _____
Subscriber's name _____DOB_____
Social Security Number_____
Patient's Relationship to the Subscriber _____ Self _____ Spouse _____ Child _____ Other

Secondary Insurance Information (we would like to photocopy your card).

Name of Insurance Company _____
Telephone Number _____
Group Number or Plan number _____
Address to send claim forms _____
City _____ **State** _____ **Zip** _____
Subscriber's name _____ **DOB** _____
Patient's Relationship to the Subscriber _____ **Self** _____ **Spouse** _____ **Child** _____ **Other**
Social Security Number _____

How did you learn about Dr. Wasserman (Please check all that apply)
____**Radio Which Station**_____
____**Google**_____
____**TV** _____
____**Referred by Doctor** _____**Referred by someone who had LASIK**
____**Referred by a Family Member**____**Other**_____

Please include the name of the person who referred you. We want to be sure to thank them. The best compliment any patient can give us is to refer their friends and family.

Name_____
Relationship to Patient_____
Address_____
City_____**State**_____**Zip**_____

In case of Emergency

Please notify
Name _____
Relationship _____ Phone _____

Private Insurance Authorization For Assignment of Benefits and Release of Information

I hereby authorize and direct payment of my medical benefits to Barry N. Wasserman, M.D., LLC, for any serviced furnished to me by the physicians. I understand that I am financially responsible for payment of any services for supplies that are deemed not medically necessary or non-covered by my insurance company. This includes refractions, contact lens examinations, and supplies. It is my responsibility to notify this office of any charge in my insurance plan before I visit. I further understand that I am responsible for charges incurred when my insurance coverage has been changed or terminated. I also authorize my insurance company to release any information required to process claims of benefits.

_____ _____
Patient (or responsible party) Signature Date

Medicare Lifetime Signature on File

I request payment of authorized MEDICARE benefits be made either to me or on my behalf to Barry N. Wasserman, M.D.,, LLC, for any services furnished to me by the physicians. I authorize any holder of medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

_____ _____
Patient (or responsible party) Signature Date

Medical History Questionnaire

Name:_____Date:_____
Do you wear glasses (circle) **YES** or **NO** If yes, how long have you had the current pair?_____
Do you wear contacts (circle) **YES** or **NO** If yes, how long have you had the current pair?_____
Do you have an interest in refractive surgery, LASIK (corrects nearsightedness, farsightedness and astigmatism) **YES** or **NO**
List any medications, including eye drops that you take:_____

_____

List any vitamins, nutritional supplements or herbs that you take:_____

_____

Do you have (circle) DIABETES / HEART DISEASE / HIGH BLOOD PRESSURE?
List all major illnesses and injuries (Date)_____

_____

List surgeries you have had:_____

Allergies to any medications or foods: Sulfa Drugs / Fluorescein Dye-Iodine-Penicillin
If others, please list:_____
Do you have any cultural/language/visual/auditory and religious factors affecting your care? **Yes** or **No**
Do you have an advance directive on file (e.g. living will or durable power of attorney for health care) if you are 18 years or older? **Yes** or **NO**
Preferred Language_____ Race_____Ethnicity_____
Do you currently have any problems in the following areas? Provide additional information for any "Yes" answer below.

Constitutional Symptoms	Yes	No	**Eyes con't**	Yes	No
Fever			Sandy or gritty feeling		
Weight Loss			Itching		
Fatigue			Burning		
Eyes			Foreign body sensation		
Loss of vision			Excess tearing/watering		
Blurred vision			Occasional tearing		
Loss of side vision			Glare/light sensitive		
Double vision			Eye pain or soreness		
Dryness			Chronic infection of eye or lid		
Mucous discharge			Sty or Chalazion		
Redness			Fluctuating visual acuity		

Please explain all "Yes" answers here:_____

_____

Physician signature_____ Date_____

Ears, nose, mouth and Throat	Yes	No	**Ear, nose, mouth and throat cont**	Yes	No
Sinus Congestion			Psychiatric depression, anxiety		
Runny nose/post nasal drip			**Family History**		
Chronic cough			Blindness		
Dry or sore throat/mouth			Cataract		
Respiratory:shortness of breath			Glaucoma		
Cardiovascular heart failure/heart attack			Macular degeneration		
Irregular heart beat			Retinal detachment		
Gastrointestinal			Arthritis		
Ulcers, heartburn			Cancer		
Urinary pain or discomfort			Diabetes		
Musculoskeletal			Heart Disease		
Skin rashes, dryness, moles, cancer			High blood pressure		
Neurological numbness, weakness			Kidney disease		
Migraine headaches			Lupus		
Stroke			Sjogrens'disease		
Endocrine heat or cold intolerance			Stroke		
Bleeding/bruising			Thyroid disease		
Allergic/immunologic/HIV or AIDS			Tuberculosis		
Allergy symptoms sneezing, itching			Other		

Please explain all "Yes" answers here:_____

Social History

Current occupation or retired from:_____
Do you drive: Yes No
Difficulty with Driving Yes No, If yes, please explain_____
Problems with night vision Yes No If yes, please explain_____
Do you drink alcohol Yes No If yes, number or drinks per week_____
Do you smoke Yes No If yes number of packs per day_____
Have you ever had a blood transfusion Yes No If yes please explain:_____
Have you ever been treated or exposed to an infectious disease (circle) Hepatitis A/ B / C
HIV or AIDS / Syphillis

Barry Wasserman M.D./New Jersey Eye Laser Centers

RECEIPT

RECEIPT OF NOTICE OF PRIVACY PRACTICES (Version 4/03)
IS HEREBY ACKNOWLEGED:

_____	_____	_____
Signature of Patient or Guardian	Print Name	Date

If signed by guardian or Power of Attorney, name of patient:

_____

The patient, or person signing for the patient named above, acknowledges receipt of a federally-required Notice of Privacy Practices, provided to you under the provisions of the Health Insurance Portability and Accountability Act of 1996. The notice describes how medical information about you (or the patient, if you are someone signing for the patient) may be used and disclosed, and how you can get access to this information. You also have certain other privacy rights under federal law, and these rights are described more fully in the Notice. You have been given a copy to take with you. Please review it carefully. The Notice helps you understand all the uses and disclosures that may be made of your medical information, and it describes your privacy rights. The Notice also indicates who you should contact if you have questions about your privacy rights. This receipt will be kept in your patient record to document that you have received this required Notice.

BARRY WASSERMAN M.D. LLC

PATIENT WAIVER FOR NON-COVERED SERVICES

Your insurance does not pay for all of your healthcare costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services.

Eg. Refraction The cost for this service is $50

I acknowledge that I have been informed in advance of receiving this service, and that this service may not covered by my health insurance plan. I understand that I will be financially responsible for the charges.

Print Patient Name _____

Patient Signature _____

Name of Parent or Legal Guardian (if applicable)_____

Signature of Parent or Legal Guardian (if applicable)_____

Date_____

This form must be signed by the patient or legal guardian PRIOR to receiving any non-covered services or items and *must be maintained in the patient's medical record.*