

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

MISYS # \_\_\_\_\_

**PATIENT INFORMATION**

LAST NAME: \_\_\_\_\_

FIRST NAME: \_\_\_\_\_

SSN: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

SEX: M \_\_\_ F \_\_\_

EMAIL: \_\_\_\_\_

MARITAL STATUS: S \_\_\_ M \_\_\_ W \_\_\_ D \_\_\_

HOME PHONE NO: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

WORK PHONE NO: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

CELL PHONE NO: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

PHONE NO: \_\_\_\_\_

PHONE NO: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

LAST NAME: \_\_\_\_\_

FIRST NAME: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

WORK/CELL PHONE: \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE CARRIER: \_\_\_\_\_

ID#: \_\_\_\_\_

GROUP #: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

SUBSCRIBER DOB: \_\_\_\_\_

SUBSCRIBER SSN: \_\_\_\_\_

EFFECTIVE DATE: \_\_\_\_\_

SECONDARY INSURANCE CARRIER: \_\_\_\_\_

ID#: \_\_\_\_\_

GROUP #: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

SUBSCRIBER DOB: \_\_\_\_\_

SUBSCRIBER SSN: \_\_\_\_\_

EFFECTIVE DATE: \_\_\_\_\_

CHIEF COMPLAINT: \_\_\_\_\_

**EYE HISTORY:**

CORNEAL DISEASE: \_\_\_\_\_

CATARACT: \_\_\_\_\_

GLAUCOMA: \_\_\_\_\_

MACULAR DEGENERATION: \_\_\_\_\_

DETACHED RETINA: \_\_\_\_\_

OTHER: \_\_\_\_\_

LIST ANY PREVIOUS EYE SURGERIES: \_\_\_\_\_

**MEDICAL HISTORY:**

DIABETES: \_\_\_\_\_

HYPERTENSION: \_\_\_\_\_

HEART DISEASE: \_\_\_\_\_

OTHER: \_\_\_\_\_

ALLERGIES TO FOOD/MEDICINE: \_\_\_\_\_

**GENERAL PRACTITIONER/MEDICAL DR:** \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NO.: \_\_\_\_\_

**PRESENT MEDICATIONS:**

<b>DRUG NAMES:</b>	<b>DOSE</b>	<b>FREQUENCY</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I authorize any holder of my medical information to release such information to the Health Care Financing Administration and its agents, or to any other insurance company.

I also authorize Corneal Associates of New Jersey to appeal or request a redetermination for any denied service on my behalf.

**I acknowledge receipt of Corneal Associates of New Jersey's Notice of Privacy Practices.**

\_\_\_\_\_  
**Signature of Patient (or Representative)**

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