Eye and Sight Center

CONFIDENTIAL MEDICAL HISTORY

Date of Last Eye Exam: _____ Where ? _____

Do you suffer from any of the following ?

	Yes	No		Yes	No
near vision blur	O	O	dry eyes	O	O
distance vision blur	O	O	watery eyes	O	O
middle distance blur (dashboard/computer)	O	O	itching/burning	O	O
double vision	O	O	pain in/around eyes	O	O
eye strain	O	O	seeing flashes	O	O
focusing trouble	O	O	seeing spots/lines	O	O
glare	O	O	headaches	O	O

Level of Satisfaction with Current Glasses: 1 2 3 4 5 6 7 8 9 10 Do you desire new glasses ? **Y** **N**
worst best

Do You or Anyone in your Family have..... ?:

O GLAUCOMA O LAZY EYE OR EYE TURN **IF SO, WHO ?**_____

O MACULAR DEGENERATION O RETINAL DETACHMENT

O CATARACTS O BLINDNESS

What is your Occupation ? _____ (Be specific so we understand your visual demands)

Describe Sports / Hobbies / Special Visual Needs: _____

Date of last general physical examination _____Do you or have you suffered from :

	Yes	No		Yes	No		Yes	No
High cholesterol	O	O	Arthritis	O	O	Kidney failure	O	O
High Blood Pressure	O	O	Acne / Eczema	O	O	Seizures / MS	O	O
Heart Attack	O	O	**Diabetes**	O	O	Shingles / Herpes	O	O
Asthma / Emphysema	O	O	Thyroid disease	O	O	Lupus	O	O
Sinus problems	O	O	Allergies	O	O	Infections	O	O
Irritable Bowel Disease	O	O	Liver disease	O	O	HIV / AIDS	O	O

Describe any Tobacco, Alcohol or Drug Use: _____ O NONE

Have you ever had a blood transfusion or been diagnosed with a STD ? **Yes O** **No O**

Are you PREGNANT or think you could be pregnant ? **Yes O** **No O**

LIST ANY CONDITION YOU HAVE NOT MENTIONED ABOVE: _____

List Current **MEDICATIONS**: None O Please List: _____ _____

_____ _____ _____ _____

List ANY **DRUG ALLERGIES**: None O Please List: _____ _____

I would like to know more about treatment options in the following areas :

O Dry Eye Treatment O Laser Vision Correction O Non-Surgical Vision Correction

_____ _____

Patient/Parent/Guardian Signature Date

EYE AND SIGHT CENTER

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____

City/State/ZIP: _____

Phone: _____Email:_____
(our office use only – appt reminders- notify etc.)

Health Insurance Co.: _____ Subscriber/ Member Name: _____

Subscriber/ Member Date of Birth: _____/_____/_____

Vision Plan (if applicable): _____

Family Doctor: _____ Phone:_____

Pharmacy: _____ Location: _____

Who referred you to our office (Physician/Friend/Relative/Internet/Insurance)? _____

PATIENT / GUARDIAN RESPONSIBILITY:

We learn about you and your insurance from the confidential information YOU PROVIDE to us. We are not agents of your employer or insurance company. There is no master list of what plan you have or if and when your coverage changes. We require your cooperation in providing accurate insurance information.

My signature below indicates my acceptance of the following:

I agree to and understand that certain ancillary tests may be performed by trained staff and/or externs. I hereby acknowledge that Drs. Gubman and Silbert are certified Preceptors authorized by the New Jersey Dept. of Law and Public Safety.

HIPPA Notification – I have received a copy of the posted HIPAA – Notice of Privacy Practices

One Time Authorization for Signature on File – I authorize and request my health insurance company to pay directly on my behalf for any/all eligible services rendered.

I understand that I am financially responsible for all services rendered and received by me or my dependents. If my insurance provider denies payment or coverage, I will pay my bill for the services and materials that I received.

X_____ Date: _____/_____/_____
Patient or Guarantor Signature (minors may not sign)

We appreciate your trust in choosing us as your Eye and Sight Specialist ! We want to assist you in every way possible so that your experience with us is pleasant and your confidence in us is well earned !

It is the mission of the Eye and Sight Center to establish Lifetime Eye-HealthCare Relationships with each patient and their family.

SCANNING RETINAL IMAGER

Comprehensive and Thorough Eye Exam without Dilating Drops: *Our Scanning Retinal Imager uses low level red and green light to digitally map your retina without dilating eye drops and bright lights. The digital map can be viewed on a computer monitor and will be shown to you during your visit with the doctor.*

92% of patients choose the retinal scan!

It is designed to detect the following:

Macular Degeneration	Diabetic Retinopathy	High Blood Pressure
Hypertensive Retinopathy	Retinal Freckles (Nevi)	Diabetes
Retinal Scars	Retinal Detachment / Tears	Some types of Cancer
Retinal Bleeding	Nearsighted Retinal Thinning	

BENEFITS TO EACH PATIENT:

Complete Retinal examination	**No dilating drops**
Eye Disease Detection	**No waiting for drops to work (20-30min)**
Systemic Disease Detection	**No blurred vision for 4-6hrs**
Better Medical documentation (digital image)	**No light/sun sensitivity for 4-6hrs**
Return to work/school with normal vision	**No driving glare for 4-6hrs**

The additional fee for the Retinal Imager is only $39
(It is NOT covered by insurance or vision plans)

I elect the Scanning Retinal Imager: _____(sign)

I request Dilating Eye Drops and Decline the Retinal Imager: _____(sign)

Do you need a CONTACT LENS Evaluation?

Contact Lens Examination: Contact Lenses are prescription medical devices and require periodic medical evaluation like any other medication. Dr. Gubman recommends at least annual visits not only to assess your vision, but more importantly, the health of your eye. Contact Lenses can and do cause complications in some patients which may not cause symptoms or complaints. These may include but are not limited to vascularization, edema and inflammation.

A Contact Lens Examination is necessary if you need a renewal of your Contact Lens Rx for ordering replacement lenses.

An Examination for contact lenses is NOT part of a regular eye examination. There is a separate fee for contact lens examinations (usually ranging from $69-$129 depending on complexity)

A. I am a Contact Lens patient and REQUEST a contact lens examination_____(Initial)
B. I am a Contact Lens patient and DECLINE a contact lens examination_____(Initial)
C. I am NOT a Contact Lens patient _____ (Initial)
D. I am NOT a Contact Lens patient, but want to talk to the Doctor about alternatives to eyeglasses:
   Initial all that Apply: (a) Multifocal Contact Lenses_____
   (b) Astigmatism Contact Lenses_____
   (c) Overnight Contact Lenses_____
   (d) Non-Surgical Vision Correction_____

Eye & Sight Center

Gubman Eye Associates, PA
303 Sheppard Road
Voorhees, NJ 08043
T: 856-751-0220 F: 856-751-0222

Woodbury Eye Associates
307 Glassboro Road
Woodbury Heights, NJ 08097
T: 856-848-5388 F: 856-848-8442

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS, EXPRESS PRIOR CONSENT TO BE CONTACTED BY EMAIL AND ON WIRELESS NUMBERS

Patient Name (Printed): _____ **Date of Birth**:_____

Home Phone :_____ **Cell Phone**:_____

Email:_____

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. In order for us to service your account or to collect monies you may owe, The Eye and Sight Center, and/or our agents may contact you by telephone at any telephone number associated with your account including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our Web site.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

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You have the option to list below, those persons with whom you authorize us to discuss your confidential information: (ie: Parents, spouse, adult children, guardian, power of attorney etc.)

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

_____ _____
Relationship to Patient Print Name

_____ ☐ Parent ☐ Legal Guardian ☐ Power of Attorney
Source of Authority

I have read and understand this consent (2 pages). I consent to the use and disclosure of my health information for purposes of treatment, payment and health care operations. I consent to being contacted for payment on wireless numbers.

_____ _____
Signature of Patient or Personal Representative Date