PATIENT INFORMATION

Information de Paciente

Name (please enter name as it appears on the insurance card)

Last Name______________________ First Name_____________________ Middle Initial_____
Apellido Primer Nombre Iniciales

Male or Female Nickname_______________ DOB__________ Social Sec #____-___-_____
Preferencia de nombre Fecha de Nacimiento Numero de seguro social

Address______________________ Apt____ City________________ State____ Zip______
Direccion Apto. Ciudad Estado Codigo Postal

Home Phone #______________ Cell Phone #____________ Work Phone #_____________
Numero de telefono de Casa Numero de telefono de Cellular Numero de telefono de Trabajo

Email ____________________________ Communication Preference Telephone /Text/Email
Correo electronico Preferencia de cumunicaccion

Race_________________ Ethnicity_____________ Preferred Language_______________
Raza Etnia Idioma preferido

Marital Status Single / Married / Divorced / Widowed
Estado Civil

Employer and Occupation____
Empleador y Trabajo

Primary Care Physician______________________________ Physician Phone #___________
Medico Primario Numero de Medico Primario

Responsible Party or Guarantor for minor_______________________ Relationship_________
Persona responsable para menor de edad Relacción

Reason for Today's Exam____

____ Razon por su visita hoy

Insurance

Vision Insurance__________________________ Policy ID#__________________________
Seguro de vision Numero de identificacion

Insurance Holders Name___________________ Relationship to Patient____________
Nombre de Asegurado Relación al Paciente

DOB___________ Soc Sec #____-___-_____ Group #_________________________
Fecha de Nacimiento Numero de seguro social Numero de Grupo

Medical Insurance__________________________ Policy ID#__________________________
Seguro medico Numero de identificacion

Insurance Holders Name___________________ Relationship to Patient____________
Nombre de Asegurado Relación al Paciente

DOB___________ Soc Sec #____-___-_____ Group #_________________________
Fecha de Nacimiento Numero de seguro social Numero de Grupo

Do you currently wear glasses? Y or N
Usas anteojos?

Do you wear contacts? Y or N
Usas lentes de contacto?

Will you be updating your glasses today? Y or N
Estarás eligiendo tus anteojos hoy?

Are you interested in contacts? Y or N
Estas interesado en lentes de contacto?

Form #6

MEDICAL HISTORY QUESTIONNAIRE

Name: ______________________________________ Today's Date: ________________
Date of Birth: _________________________________

Primary Care Physician: (medical doctor) ____
Date of Last Visit to Primary Care Physician: __________________________

Allergies: ____
____

Eye Health History: (Please a mark "Yes" or "No" to all that apply.)

Blindness	[ ]YES [ ]NO		
Bloodshot Eyes	[ ]YES [ ]NO	Floaters or Spots	[ ]YES [ ]NO
Blurred Vision – Distance	[ ]YES [ ]NO	Glaucoma	[ ]YES [ ]NO
Blurred Vision – Near	[ ]YES [ ]NO	Headaches	[ ]YES [ ]NO
Burning Eyes	[ ]YES [ ]NO	Itching Eyes	[ ]YES [ ]NO
Cataracts	[ ]YES [ ]NO	Lazy Eyes	[ ]YES [ ]NO
Color Vision, Poor	[ ]YES [ ]NO	Light Sensitive	[ ]YES [ ]NO
Crossed Eyes	[ ]YES [ ]NO	Loss of Vision	[ ]YES [ ]NO
Discharge from Eyes	[ ]YES [ ]NO	Migraine Headaches	[ ]YES [ ]NO
Dizzy Spells	[ ]YES [ ]NO	Night Vision – Poor	[ ]YES [ ]NO
Double Vision	[ ]YES [ ]NO	Red Eyes	[ ]YES [ ]NO
Dry Eyes	[ ]YES [ ]NO	Seeing Halos	[ ]YES [ ]NO
Eye Infection	[ ]YES [ ]NO	Seeing Flashes	[ ]YES [ ]NO
Eye Injury	[ ]YES [ ]NO	Temporary Loss of Vision	[ ]YES [ ]NO
Eye Strain	[ ]YES [ ]NO	Twitching Eyelid	[ ]YES [ ]NO
Eye Surgery	[ ]YES [ ]NO	Vision Poor	[ ]YES [ ]NO
Fainting Spells, Blackouts	[ ]YES [ ]NO	Watering Eyes	[ ]YES [ ]NO

Health History: (Please a mark "Yes" or "No" to all that apply.)

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	[ ]YES [ ]NO	[ ]YES	High Blood Pressure	[ ]YES [ ]NO	[ ]YES
Arthritis	[ ]YES [ ]NO	[ ]YES	Kidney Disease	[ ]YES [ ]NO	[ ]YES
Asthma	[ ]YES [ ]NO	[ ]YES	Lupus/Autoimmune Disease	[ ]YES [ ]NO	[ ]YES
Cancer	[ ]YES [ ]NO	[ ]YES	Migraine Headaches	[ ]YES [ ]NO	[ ]YES
Diabetes	[ ]YES [ ]NO	[ ]YES	Shingles	[ ]YES [ ]NO	[ ]YES
Epilepsy	[ ]YES [ ]NO	[ ]YES	Skin Conditions	[ ]YES [ ]NO	[ ]YES
Hay Fever	[ ]YES [ ]NO	[ ]YES	Stroke	[ ]YES [ ]NO	[ ]YES
Heart Condition	[ ]YES [ ]NO	[ ]YES	Thyroid Conditions	[ ]YES [ ]NO	[ ]YES
HepatitisA/B/C	[ ]YES [ ]NO	[ ]YES	Tuberculosis	[ ]YES [ ]NO	[ ]YES

Medications: (Please list any medications you are currently taking, including eye drops.)
____
____
____

Are you pregnant?________________ Tobaccco use?_______________ Alcohol use?________________

BERGEN OPTOMETRY, LLC.
Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Request for Limitations and Restrictions of Protected Health Information

I, give my permission for you to speak to the following person(s) regarding my health information:

____
Name   Phone   Relationship

____
Name   Phone   Relationship

With my consent, **Bergen Optometry, LLC.** may use and disclose protected health information **(PHI)** about me to carry out treatment, payment and healthcare operation **(TPO)**.

I have the right to review the **Notice of Privacy Practices** prior to signing this consent. **Bergen Optometry, LLC.** reserves the right to revise its' **Notice of Privacy Practices** at any time.

With my consent, **Bergen Optometry, LLC.** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out **TPO,** such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

By signing this form, I am consenting to **Bergen Optometry, LLC.'s** use and disclosure of my **PHI** to carry out **TPO.** I am acknowledging that I have received **Bergen Optometry, LLC.'s Notice of Privacy Practices** for review.

I may revoke or revise my consent in writing except to the extent that the practice had already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Bergen Optometry, LLC.** may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian   Date

____
Patient's Name (Please Print)   Date

Form #8

BERGEN OPTOMETRY, LLC.
348 Main Street
Hackensack, NJ 07601
Phone: (201)-342-4255 Fax: (201)-487-4886
Website: www.bergenoptometry.com

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

PATIENT NAME: ____ **DATE OF BIRTH:** ____________

The practice appreciates the confidence you have shown in choosing us to provide for your health care needs. The services you have elected for the practice to provide imply a financial responsibility on your part. The practice will request your most updated insurance information at each visit, and verify your coverage whenever it can. We will bill your insurance carrier on your behalf; however you are ultimately responsible for payment of your bill due to the practice.

In addition you are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible to understand your insurance coverage and be aware of any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I acknowledge that I have requested an exam/treatment/or other services from **Bergen Optometry, LLC.**, and I authorize my insurer to pay any benefits directly to **Bergen Optometry, LLC.** for all services rendered. Whatever amounts are not paid by my insurer, I agree to be personally responsible for.

By my signature below, I acknowledge that I have read and understand the protocol of **Bergen Optometry, LLC.** concerning my financial responsibilities to the practice.

______________________________ ______________________________
Patient Signature & Date Parent/Guarantor Signature & Date

CANCELLATION OR MISSED APPOINTMENTS

We understand, there may be times when you miss an appointment due to emergencies or obligations to work or family, however, we urge you to call 24 hours prior to your scheduled appointment time. I understand that if I do not show for 2 or more consecutive appoints, and cancel or do not show for a total of 3 consecutive appointments, I may be discharged from the practice.

By my signature below, I acknowledge that I have read and understand the protocol of **Bergen Optometry, LLC.** concerning last minute cancellations and missed appointments.

______________________________ ______________________________
Patient Signature & Date Parent/Guarantor Signature & Date

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice may accept both:

1. Vision Care Plans (such as VSP, EyeMed, Davis Vision, & Superior)
2. Medical Insurance (such as BCBS, Medicare, Cigna & Aetna)

- Vision care plans ONLY cover routine exams and may cover some materials (such as glasses or contacts). Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.

- Medical insurance must be used if you have any eye health problems or systemic health problems that have ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.

- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. Whenever possible, we will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.

- We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered, however, you are responsible to know the benefits and allowances of your plan. If some fees are not paid by your own plan, we will bill you for any unpaid deductibles, co-pays, or non-covered services as allowed by the insurance contract. We will bill your insurance plan for services rendered if we are a participating provider for that plan.

- While Bergen Optometry, LLC is happy to file my insurance for me, I understand I am responsible for all co-payments and balances.

Insurance Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits and I authorize payment of these benefits directly to Bergen Optometry, LLC on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 of the CMS-1500 Claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

By signing below, I certify that I have read and understand all of the above.

____

Print Name

______________________________ ______________

Sign Name **Date**

Form #5