Retina Center of New Jersey, LLC

Dr. Patrick M. Higgins
Dr. Lauren A. Kallina
Dr. Louis V. Angioletti
Dr. Kurt T. Jackson
Dr. Lee M. Angioletti
Dr. Justin Gutman

Diseases and Surgery of the Retina, Macula and Vitreous

1255 Broad Street, Ste. 104	6121 Kennedy Blvd., 1st Fl.	500 N. Franklin Tpke., Ste. 205	1086 Teaneck Rd., Ste. 2A	1095 Morris Avenue, Ste. 103A
Bloomfield, NJ 07003	North Bergen, NJ 07047	Ramsey, NJ 07446	Teaneck, NJ 07666	Union, NJ 07083
Tel: 973-707-5632	Tel: 201-766-5151	Tel: 201-962-9396	Tel: 201-871-3414	Tel: 908-312-1001
Fax: 973-707-7349	Fax: 201-766-5154	Fax: 201-962-9399	Fax: 201-871-4830	Fax: 908-312-1005

NEW PATIENT CHECKLIST

In trying to make your visit to RCNJ (Retina Center of New Jersey) as pleasant as possible, we would like to provide you with a checklist and brief summary of what to expect.

☐ **Internist/Primary Care Physician Referral**
If a referral is needed for your appointment based on your insurance carrier's policy, it is your responsibility to bring it with you. In the event that a valid referral is not provided to us on the day of your visit, you will be given the option to reschedule your appointment OR pay for your visit in full and we will reimburse you if we get paid by your insurance

☐ **Referral Note From Your Physician**
Please bring any note provided by your physician that describes the reason for your visit

☐ **Driver's License or Passport**

☐ **All Insurance cards (Primary Insurance, Secondary Insurance, Medicare, Medicaid, etc.)**

☐ **Method Of Payment (Cash, Check or Credit Card)**
Deductibles, Co-Payments and any outstanding balances owed are due at the time of service

☐ **List of Medications**
Bring a list of all oral medications and eye drops you are currently taking, including the name and dosage amount of the drug (bring the actual medication with you if possible).

☐ **Medical Records**
Copies of any Eye Exams or medical records that may be import to share with the physician

☐ **Completed Patient Forms Packet (all 4 forms must be completed for New Patient Visits)**
- ☐ **New Patient Registration Form**
- ☐ **HIPAA Notice of Privacy Practice Form**
- ☐ **No Show and Cancellation Policy Form**
- ☐ **Patient Ophthalmic & Medical Questionnaire Form**

New Patients should arrive fifteen minutes prior to your appointment will give us sufficient time to make sure your records have the current and important information we need.

Please allow approximately two hours for your appointment because if needed, we may need to conduct many tests. Your visit will require your eyes to be dilated which will enlarge your pupils. After the examination, your close-up vision may remain blurred and you may experience sensitivity to light that typically lasts 4-6 hours.

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PATIENT REGISTRATION FORM

First Name **MI** **Last Name**		**Suffix**	**Sex: M / F**
Home Address		**Date of Birth**	
City	**State**	**Zip Code**	
Preferred Language	Race ☐ Native American (Indian) ☐ Black/African American ☐ Asian		
Ethnicity ☐ Hispanic Origin. ☐ Not of Hispanic Origin	☐ Native Hawaiian/Pacific Islander ☐ Hispanic or Latino ☐ White		
Home #	Work #	Cell #	
Social Security #	Marital Status ☐ S ☐ M ☐ D ☐ W	E-mail	
Patients' Employer Name, Address / Occupation			
Emergency Contact Name	Phone #	Relationship	
Referring Physician/	Phone #	City	
Primary Care Physician	Phone #	City	
Financially responsible person (if different from patient)			
Responsible person's address:		Phone #	
***Are you currently residing in a Skilled Nursing Facility or Rehabilitation Center?		☐ Yes ☐ No	
If yes, name and address of facility		Phone #	

INSURANCE INFORMATION

Primary Insurance:	Policy Holder Name:	DOB:	Sex: M / F
Address:			
ID #:	Group #:	Effective Date:	
Secondary Insurance:	Policy Holder Name:	DOB:	Sex: M / F
Address:			
ID #:	Group #:	Effective Date:	

FINANCIAL POLICY STATEMENT

Thank you for choosing 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 will be responsible for any balances not covered by your insurance. A return check fee of $35.00 will be assessed if your check is returned by your bank. Our cancellation and "no show" policy is as follows: First occurrence, patient will be charged a $25.00 fee. Second occurrence, patient will be charged a $35 fee. Third occurrence, patient will be charged a $50 fee. The patient may be charged the full price of the scheduled office visit for any additional "no show" or any appointment cancellation that occurs within 24 hours of a scheduled appointment.

HIPAA - This office will comply with all aspects as printed in our Notice of Privacy Practice, and our privacy notice will be in compliance with all appropriate laws and regulations.

PATIENT AUTHORIZATION

I hereby authorize Eye Centers of America, 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 Eye Centers of America, 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.

I hereby attest that I have been given and reviewed the Notice of Privacy Practice.

Patient Signature_____ Date _____

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HIPAA NOTICE OF PRIVACY PRACTICE

Privacy Consent

I understand that Eye Centers of America, LLC, "Notice of Privacy Practices" provides how my health information will be used and disclosed. The "Patient Rights" section describes my rights under the law. I have the right to review the notice before signing this consent. I understand that this notice may change and that I can request a revised copy. I understand that I have the right to request that we restrict how protected health information about me is disclosed for treatment, payment, or health care operations. I understand that Eye Centers of America, LLC, is not required to agree to this restriction, but you will honor this agreement.

I acknowledge by signing this form I consent to your use and disclosure to protect health information about my treatment, payment, and health care operations. I have the right to revoke this consent in writing with my signature. However, this revocation shall not affect any disclosures Eye Centers of America, LLC has already made in reliance prior to my consent. Eye Centers of America, LLC, provides this form to me to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Consent to Release Information

I acknowledge that by signing this form, I permit Eye Centers of America, LLC, to release any information to the physician(s) involved in my care. I consent that Eye Centers of America, LLC, may call my house or designated locations and leave a message on voice mail or in person in reference to my appointment reminders and insurance items. In addition, Eye Centers of America LLC, may mail to my home appointment reminders and patient statements.

I designate the following representative(s) as being legally authorized to communicate with Eye Centers of America, LLC, on my behalf. If you do not designate anyone below, the Doctor/Eye Centers of America, LLC, will not be able to speak with anyone besides the patient regarding your medical condition.

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Signature on file

I request that the payment of authorized benefits be made on my behalf to EYE CENTERS OF AMERICA, LLC. I authorize any holder of medical information about me be release to Novitas Medicare Solutions or any other of my medical carriers and any information needed to determine benefits or benefits payable for related services.

Patient Name:_____ Date of Birth: _____

Signature (Patient or Legal Guardian): _____ Date: _____

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NEW PATIENT MEDICAL HISTORY FORM

Name: _____ Date of Birth: ___/____/_____ Height: _____ Weight: _____

REASON FOR REFERRAL / VISIT (TELL US WHY YOU ARE HERE):

_____

_____

_____

_____

CHIEF COMPLAINTS (TELL US WHAT IS BOTHERING YOU):

○ Loss of Central Vision	○ Glare from Bright Lights	○ Swollen Eyelids
○ Loss of Peripheral Vision	○ Glare from Car Headlights	○ Droopy Eyelids
○ Loss of Night Vision	○ Glare from the Sun	○ Twitching of Eyelids
○ Loss of Distance Vision	○ Tearing from Bright Lights	○ Floppy Eyelids
○ Loss of Reading Vision	○ Tearing from the Sun	○ Poor Eyelid Closure
○ Loss of Color Vision	○ Headaches	○ Bumps on Eyelid
○ Flashes of Light	○ Watery Discharge	○ Growth on Eyelid
○ Floaters	○ Mucous Discharge	○ Itchiness of Eyelids
○ Shadow in Peripheral Vision	○ Crusty Discharge	○ Rash on Eyelids
○ Distortion (of Straight Lines)	○ Sand-Like Discharge	○ Redness of Eyelids
○ Objects Appear Smaller	○ Aching Eye Pain	○ Other:
○ Sensitivity to Bright Lights	○ Burning Eye Pain	○
○ Sensitivity to Car Headlights	○ Pinching Eye Pain	○
○ Sensitivity to the Sun	○ Stabbing Eye Pain	○
○ Halos Around Car Headlights	○ Foreign Body Sensation	○

Location: What is the site of the problem/which eye? ☐ Right Eye ☐ Left Eye ☐ Both Eyes

Quality: What is the nature of the pain? ☐ Constant ☐ Intermittent ☐ Improving ☐ Worsening

Severity: Describe the severity of your pain/problem (on a scale of 1 to 10, with 10 being the worst) _____

Duration: When did the pain/problem start?_____

How long has the pain/problem been an issue?_____

Timing: Is the pain/problem worse in the morning, evening, or is it constant?_____

Context: Is the pain/problem associated with an activity? _____

Modifiers: What efforts has the patient made to improve the pain/problem (i.e. heat, artificial tears, other, etc.)?

_____

CONSTITUTIONAL SYMPTOMS

Good General Health Lately	☐Yes	☐No
Recent Weight Change	☐Yes	☐No
Fever	☐Yes	☐No
Fatigue	☐Yes	☐No
Headaches	☐Yes	☐No
Insomnia	☐Yes	☐No
Hours of Sleep Each Night	_____	

PSYCHIATRIC

Memory Loss or Confusion	☐Yes	☐No
Nervousness	☐Yes	☐No
Depression	☐Yes	☐No
Insomnia	☐Yes	☐No
Anxiety	☐Yes	☐No

HEMATOLOGIC/LYMPHATIC

Slow to Heal After Cuts	☐Yes	☐No
Bleeding or Bruising Tendency	☐Yes	☐No
Anemia	☐Yes	☐No
Phlebitis	☐Yes	☐No
Past Transfusion	☐Yes	☐No
Enlarged Glands	☐Yes	☐No
Blood Transfusion	☐Yes	☐No
Transfusion Reaction	☐Yes	☐No

RESPIRATORY

Chronic or Frequent Cough	☐Yes	☐No
Spitting up Blood	☐Yes	☐No
Shortness of Breath	☐Yes	☐No
Asthma or Wheezing	☐Yes	☐No
Shortness of Breath While Walking or Lying	☐Yes	☐No
Recent Upper Respiratory Infection	☐Yes	☐No
Sleep Apnea	☐Yes	☐No

INTEGUMENTARY

Rash or Itching	☐Yes	☐No
Change in Skin Color	☐Yes	☐No
Change in Hair and Nails	☐Yes	☐No
Varicose Veins	☐Yes	☐No
Breast Pain	☐Yes	☐No
Breast Lump	☐Yes	☐No
Breast Discharge	☐Yes	☐No
Skin Disorders	☐Yes	☐No

NUTRITION

Supplements	☐Yes	☐No
Tube Feed	☐Yes	☐No
Eating Disorder	☐Yes	☐No
Vitamins/Minerals/Herbals	☐Yes	☐No
Liver Failure	☐Yes	☐No
Difficulty Swallowing	☐Yes	☐No
Unintentional Weight Loss in 3 months	☐Yes	☐No

MUSCULOSKELETAL

Arthritis	☐Yes	☐No
Joint Pain	☐Yes	☐No
Joint Stiffness or Swelling	☐Yes	☐No
Muscle or Joint Weakness	☐Yes	☐No
Muscle Pain or Cramps	☐Yes	☐No
Muscular Disorder	☐Yes	☐No
Back Pain	☐Yes	☐No
Cold Extremities	☐Yes	☐No
Difficulty in Walking	☐Yes	☐No
Spine Disease	☐Yes	☐No
Fractures	☐Yes	☐No

EAR, NOSE, MOUTH AND THROAT

Hearing Loss or Ringing	☐Yes	☐No
Hearing Aids	☐Yes	☐No
Earaches or Drainage	☐Yes	☐No
Chronic Virus Problems	☐Yes	☐No
Rhinitis	☐Yes	☐No
Nose Bleeds	☐Yes	☐No
Mouth Sores	☐Yes	☐No
Bleeding Gums	☐Yes	☐No
Bad Breath or Bad Taste	☐Yes	☐No
Sore Throat/Voice Change	☐Yes	☐No
Swollen Glands in Neck	☐Yes	☐No

NEUROLOGICAL

Frequent Urination	☐Yes	☐No
Light Headed or Dizzy	☐Yes	☐No
Convulsions or Seizures	☐Yes	☐No
Numbness or Tingling	☐Yes	☐No
Tremors	☐Yes	☐No
Weakness or Paralysis	☐Yes	☐No
Stroke	☐Yes	☐No
Head Injury	☐Yes	☐No
Speech Difficulties	☐Yes	☐No
Change in Gait	☐Yes	☐No
Vision Difficulties	☐Yes	☐No
Glasses/Contact Lenses	☐Yes	☐No

CARDIOVASCULAR

Heart Trouble	☐Yes	☐No
Chest Pain	☐Yes	☐No
Angina Pectoris	☐Yes	☐No
Palpitations	☐Yes	☐No
No Heat or Cold Intolerance	☐Yes	☐No
Swelling of Feet or Ankles	☐Yes	☐No
Pacemaker	☐Yes	☐No
Myocardial Infarction	☐Yes	☐No
Hypertension	☐Yes	☐No
Heart Failure	☐Yes	☐No
Valve Disease	☐Yes	☐No
Heart Murmur	☐Yes	☐No
Irregular Rhythm	☐Yes	☐No
High Cholesterol	☐Yes	☐No
Peripheral Vascular Disease	☐Yes	☐No

ENDOCRINE

Glandular or Hormonal Problems	☐Yes	☐No
Thyroid Disease	☐Yes	☐No
Excessive Thirst or Urination	☐Yes	☐No
Skin Becoming Dryer	☐Yes	☐No
Change in Hat or Glove Size	☐Yes	☐No
Diabetes	☐Yes	☐No
When were you diagnosed?	_____	
Type 1 or Type 2 (Please Circle)		
HGB A1C/HbA1c?_____ Date:_____		
Are You on Insulin	☐Yes	☐No
Times Per Day	_____	
Are You on Dialysis	☐Yes	☐No

GENITROURINARY

Frequent Urination	☐Yes	☐No
Burning or Painful Urination	☐Yes	☐No
Blood in Urine	☐Yes	☐No
Change in Force or Stream	☐Yes	☐No
Incontinence or Dribbling	☐Yes	☐No
Kidney Stones	☐Yes	☐No
Sexually Transmitted Disease	☐Yes	☐No
Sexual Difficulty	☐Yes	☐No
Male - Testicle Pain	☐Yes	☐No
Prostate Problems	☐Yes	☐No
Female - Pain with Periods	☐Yes	☐No
Female - Irregular Periods	☐Yes	☐No
HIV	☐Yes	☐No

GASTROINTESTINAL

Loss of Appetite	☐Yes	☐No
Change in Bowel Movements	☐Yes	☐No
Nausea or Vomiting	☐Yes	☐No
Frequent Diarrhea	☐Yes	☐No
Painful Bowel Movements or Constipation	☐Yes	☐No
Rectal Bleeding or Blood in Stool	☐Yes	☐No
Abdominal Pain or Heartburn	☐Yes	☐No
Peptic Ulcer (Stomach or Duodenal)	☐Yes	☐No
Hiatus Hernia	☐Yes	☐No
Gastrointestinal Problems	☐Yes	☐No
Hemorrhoids	☐Yes	☐No
Pancreatitis	☐Yes	☐No
Hepatitis	☐Yes	☐No
Liver Disease	☐Yes	☐No
Renal Disease	☐Yes	☐No

PAST MEDICAL HISTORY

Medical Condition	Year of Onset

CURRENT MEDICATIONS

Name	Dosage

PAST SURGICAL HISTORY

Surgeries	Date

Anesthesia Complications ☐Yes ☐No

If yes, explain:

_____

_____

PATIENT SOCIAL HISTORY

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Use of Tobacco
- ☐ Never
- ☐ Previous but Quit
- ☐ Currently
- _____ Packs Daily

Use of Illicit Drugs
- ☐ Never
- ☐ Type & Frequency
- _____
- _____

Use of Alcohol
- ☐ Never
- ☐ Rarely
- ☐ Moderate
- ☐ Daily

Excessive Exposure at Home or Work to:
- ☐ Fumes_____
- ☐ Solvents_____
- ☐ Chemicals_____
- ☐ Other_____

FAMILY MEDICAL HISTORY

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Brother(s)			
Sister(s)			
Spouse			
Children			

Living Will/Advance Directive ☐Yes ☐No ☐Would Like Information

PLEASE INFORM THE DOCTOR OF ALL PHYSICIANS

YOU ARE CURRENTLY SEEING

SPECIALTY	PHYSICIAN NAME	ADDRESS	PHONE NUMBER
Ophthalmologist			
Optometrist			
Internist			
Endocrinologist			
Cardiologist			
Nephrologist			
Neurologist			
Podiatrist			
Vascular Specialist			
Other			