Eye Care
PHYSICIANS & SURGEONS
of New Jersey

Patient Registration Sheet

Patient Name: _____Age:_____

Address: _____Apartment #: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ ***Please circle preferred method of contact for appointment reminders***

Home Phone: (___)___-_____ Work Phone: (___)___-_____ Cell Phone: (___)___-_____

Gender: □M □ F Marital Status: _____Birth Date: ___/___/_____Social Security Number: ____-____-_____

Pharmacy Name:_____ Phone: (____)____-_____

Employer: _____ Occupation: _____

Emergency Contact:_____ Phone: (___)___-_____ Relationship: _____

Who referred you to Eye Care Physicians? _____

Race: □ American Indian / Alaskan Native □ Asian □ Caucasian **Ethnicity:** □ Hispanic □ Non – Hispanic
□ Native Hawaiian or Other Pacific Islander □ Other
□ Hispanic/Latino □ African American □ Decline to Answer Preferred Language: _____

Insurance Information

Primary Insurance:_____ **Insured Name:** _____

Insured Phone: ( ) ___-_____ Relationship: _____ Birth Date: ___/___/_____

Insured Employer: _____ Insured SS#: ____-____-_____

ID #: _____ Group / Policy #: _____ Co-pay $ _____

Secondary Insurance: _____Insured Name: _____

Insured Phone: ( )___-_____ Relationship:_____ Birth Date: ___/___/_____

Insured Employer: _____ Insured SS#: ____-____-_____

ID #: _____Group / Policy #: _____ Co-pay $ _____

Vision Coverage Plan Name: _____ ID#: _____ Relationship: _____

Insured Name: _____ Insured SS#: ____-____-_____ Insured DOB: ___/___/_____

To Be Filled out only if Workman's Compensation

Names of Company: _____ Phone (___) ___-_____

Address: _____ Contact Person: _____

Financial Assignment and Agreement

1. I request the payment of the authorized Medicare and/or insurance benefit be made on my behalf to Eye Care Physicians and Surgeons of New Jersey for any services furnished me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration, its agents for any insurance carrier I may have, any information needed to determine these benefits payable for related services.

2. This assignment will remain in effect and revoked by me in writing. A photocopy of this is to be considered as valid as an original. I understand that I am financial responsible for all charges whether or not paid by said insurance. I hereby authorize and assign to release all information needed to secure the payment.

_____ _____ ___/___/_____

Signature of patient / patient representative Relationship Date

Review Of Systems

Eyes

Previous Surgery	Yes ☐ No ☐
Contact Lens	Yes ☐ No ☐
Pain	Yes ☐ No ☐
Double Vision	Yes ☐ No ☐
Glaucoma	Yes ☐ No ☐
Cataracts	Yes ☐ No ☐
Macular Degeneration	Yes ☐ No ☐
Dry Eyes	Yes ☐ No ☐
Flashes	Yes ☐ No ☐
Floaters	Yes ☐ No ☐

Ear, Nose, and Throat

Hard of Hearing	Yes ☐ No ☐
Ringing in Ears	Yes ☐ No ☐
Vertigo	Yes ☐ No ☐

Cardiovascular

Chest Pain	Yes ☐ No ☐
Dizziness	Yes ☐ No ☐
Fainting Spells	Yes ☐ No ☐
Shortness of breath	Yes ☐ No ☐
Irregular Heart Beat	Yes ☐ No ☐
Difficulty Lying Flat	Yes ☐ No ☐

Constitutional

Fatigue/Weakness	Yes ☐ No ☐
Fever	Yes ☐ No ☐
Weight Gain/Loss	Yes ☐ No ☐

Respiratory

Cough	Yes ☐ No ☐
Congestion	Yes ☐ No ☐
Wheezing	Yes ☐ No ☐
Asthma	Yes ☐ No ☐

Endocrine

Increased Thirst	Yes ☐ No ☐
Increased Hunger	Yes ☐ No ☐
Increased Urination	Yes ☐ No ☐
Increased Sweating	Yes ☐ No ☐
Fingernail Changes	Yes ☐ No ☐

Gastrointestinal

Heartburn	Yes ☐ No ☐
Nausea/Vomiting	Yes ☐ No ☐
Jaundice/Hepatitis	Yes ☐ No ☐

Genito-Urinary

Pain/Difficulty	Yes ☐ No ☐
Blood in urine	Yes ☐ No ☐
History of Kidney stones	Yes ☐ No ☐
History of STD's	

Psychiatric

Anxiety/Depression	Yes ☐ No ☐
Mood Swings	Yes ☐ No ☐
Difficulty Sleeping	Yes ☐ No ☐

Blood/Lymphnodes

Easy Bruising	Yes ☐ No ☐
Gums Bleed Easily	Yes ☐ No ☐
Prolonged Bleeding	Yes ☐ No ☐
Heavy Aspirin Use	Yes ☐ No ☐

Musculoskeletal

Stiffness	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐
Joint Pain/Swelling	Yes ☐ No ☐

Skin

Rash/Sores	Yes ☐ No ☐
Lesions	Yes ☐ No ☐
Hives/Eczema	Yes ☐ No ☐

Neurological

Seizures	Yes ☐ No ☐
Weakness/Paralysis	Yes ☐ No ☐
Numbness	Yes ☐ No ☐
Tremors	Yes ☐ No ☐

Immunologic

Hives	Yes ☐ No ☐
Itching	Yes ☐ No ☐
Runny Nose	Yes ☐ No ☐
Sinus Pressure	Yes ☐ No ☐

Signature: _____