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: _____