Salzano Eye Center, LLC

Eyecare Registration and History Form

195 Fairfield Avenue, Suite 2B, West Caldwell, NJ 07006

1 Patient Information

Date: _____

Patient: _____

Address: _____

_____

City: _____

State: _____ Zip: _____

Phone: _____

Email: _____

Gender: ☐ M ☐ F Age: _____ DOB: _____

☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced

Patient SS# (Last 4 Digits): _____

Occupation: _____

Employer: _____

Name of Primary Doctor _____

Phone: _____

Town: _____

Pharmacy: _____

Phone: _____

Town: _____

2 Insurance

Primary Insurance: _____

Subscriber: _____

Relationship to Patient: _____

Subscriber DOB: _____

Secondary Insurance: _____

Subscriber & DOB: _____

Do you need a **referral** to see Dr. Salzano? ☐ Yes ☐ No

Vision Plan: ☐ Yes ☐ No

Name of Plan: _____

Member's Name: _____

Member's DOB: _____

Last 4 digits of SS#: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assigned directly to Dr. Salzano all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:

Signature _____

Relationship: _____ Date: _____

Vision Plans are for routine exams ONLY! Medical Plans are for problems, follow-ups or testing visits.

3 HIPAA Privacy Authorization

Please list the names and relationships of the people with whom we can discuss your medical issues:

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Reason for Today's Visit: ☐ Routine ☐ Problem ☐ Date of Last Exam: _____

Do you wear glasses: ☐ Yes ☐ No ☐ All the time ☐ Driving ☐ Reading

Do you wear contacts: ☐ Yes ☐ No

Please bring glasses and contact information

If there are no changes from the last time you filled this form, initial and date here. _____

4 Eye Health History

Please mark to indicate if you have had any of the following.

- Bloodshot Eyes ☐
- Blurred Vision- Distance ☐
- Blurred Vision - Near ☐
- Burning Eyes ☐
- Cataracts ☐
- Color Vision Poor Crossed ☐
- Eyes/Strabismus ☐
- Discharge from Eyes ☐
- Dizzy Spells ☐
- Double Vision ☐
- Dry Eyes ☐
- Eye Infection ☐
- Eye Injury ☐
- Eye Strain ☐
- Eye Surgery ☐
- Fainting Spells, Blackouts ☐
- Floaters or Spots ☐
- Glaucoma ☐
- Headaches ☐
- Itching Eyes ☐
- Light Sensitive ☐
- Loss of Vision ☐
- Macular Degeneration ☐
- Migraine Headaches ☐
- Night Vision Poor ☐
- Red Eyes ☐
- Retinal Disease ☐
- Seeing Halos ☐
- Seeing Flashes ☐
- Temporary Loss of Vision ☐
- Twitching Eyelid ☐
- Vision Poor ☐
- Watering Eyes ☐

Family Eye History: Check all that apply

☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Disease

5 Medications

List the medications you are currently taking, including eye drops:

_____

_____

_____

_____

_____

_____

_____

Allergies

List your allergies to medications or other

_____

_____

_____

_____

_____

_____

_____

6 Health History

Physician's Name: Date of last visit: Please mark to indicate if you have had any of the following.

- **AIDS/HIV** ☐
- **Arthritis** ☐
- **Artificial Heart Valve** ☐
- **Asthma** ☐
- **Bleeding** ☐
- **Cancer** ☐
- **Chemical Dependency** ☐
- **Diabetes** ☐
- Drug Sensitivity ☐
- Emphysema ☐
- Epilepsy ☐
- Hay Fever ☐
- Heart Condition ☐
- Hepatitis (Type___) ☐
- High Blood Pressure ☐
- Kidney Disease ☐
- Lupus ☐
- Pacemaker ☐
- Rheumatic Fever ☐
- Shingles ☐
- Skin Conditions ☐
- Stroke ☐
- Thyroid Conditions ☐
- Tuberculosis ☐

If Under 18 **Birth History**: #Weeks_____Complications_____ **Tobacco use** ☐ **Alcohol Use** ☐

Eye Surgery: Type_____ Year_____

Surgery(Other): Type_____ Year_____

If there are no changes from the last time you filled this form, initial and date here. _____

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Refraction/Testing Waivers

MEDICARE PATIENTS ONLY

MEDICARE WILL **NOT** COVER THE COST OF THE REFRACTION.
****Refraction is the part of the exam that determines your prescription for either glasses or contacts.*** We do submit to secondary insurance, however, we do not know how much your insurance will cover, **if any.** The most this service will cost you is **$65.00 and you will receive a prescription for glasses and/or contacts.**

I understand that Medicare **will NOT** cover the cost of this service. I agree to be personally and fully responsible for payment. That is, I will receive a bill and be financially responsible if any secondary insurance doesn't cover this service**.**

Check one:

☐ Yes, I want to receive the items or services.
☐ No, I have decided not to receive the items or services.

Signature:_____ Date: _____

MEDICAL PATIENTS ONLY

REFRACTION FOR GLASSES PRESCRIPTION

YOUR INSURANCE MAY OR MAY NOT COVER THE COST OF THE REFRACTION.
****Refraction is the part of the exam that determines your prescription for either glasses or contacts.*** We do submit to your insurance however, we do not know how much your insurance will cover, **if any.** The most this service will cost you is **$65.00 and you will receive a prescription for glasses and/or contacts.**

I agree to be personally and fully responsible for the payment once I receive a bill for this service.

Check one:

☐ Yes, I want to receive the items or services.
☐ No, I have decided not to receive the items or services.

Signature:_____ Date:_____

VISION PATIENTS ONLY:

Office Visit/Testing Acknowledgement Form

I (or my dependent), _____ acknowledge that I will be billed for an **OFFICE VISIT** to address **non-routine eye exam** medical diagnoses and/or the **TESTING** done on this visit. Testing may include one or more of the following: digital photography, visual field, and/or optic nerve imaging. These charges along with the office visit **MAY OR MAY NOT BE** be paid for by my insurance. I acknowledge that I will be responsible for any balance due **after it is processed** through my insurance. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits.

Signature: _____Date: _____

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CHOOSE ONE OPTION

CONSENT FOR DILATION

Consent to use dilating DROPS

Dilating eye drops are used to enlarge the pupils, allowing Dr. Salzano to examine the inside of your eye. For many types of eye examinations, this is usually a requirement.

Dilating drops will usually cause blurred vision. Bright sunlight also can make it difficult to see. The length of time that your vision will be blurred, and the degree to which your eyesight is impaired, varies from patient to patient.

Therefore, we strongly suggest you make arrangements for transportation. If you do choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself and others. In addition, adverse reactions, such as acute angle-closure glaucoma, may be triggered from the use of dilating drops. This is extremely rare and treatable with immediate medical attention.

Signature:_____ Date:_____

OR

Consent for Non-Mydriatic Fundus PHOTO

For a faster and more thorough eye exam, we are offering an ultra-widefield imaging system that replaces dilation. **Insurance WILL NOT pay** for this photography.

The additional cost to you, our patient, is $39.00

If you would like to take advantage of this specialized photography,
Please sign the consent form below:

I agree to pay the sum of **$39** for a non-mydriatic fundus photograph of my eyes. This photograph is taken through **UNDILATED** pupils, and is used for the following purposes:

1. **Screening** for vitreoretinal and optic nerve pathology, such as glaucoma, macular degeneration, retinal tears, and retinal detachments.
2. **Documenting** the general health of the back portion of the eye (fundus), which we would not be able to see, otherwise, without dilation of the pupils.

Signature:_____ Date:_____

*This charge is only for this procedure, and not for any other routine testing usually covered by insurance.