Giliberti Eye & LASER CENTER

NEW PATIENT REGISTRATION FORM

Patient Information:

First Name:		**Mi:**	**Last Name:**
Date of Birth:	**Age:**	**Sex: M / F**	**SSN:**
Home Address:			**Apt. #:**
City:		**State:**	**Zip Code:**
Language:	**Race:** White ☐ Black ☐ Asian ☐ Native American ☐ Other ☐		
Ethnicity: Non-Hispanic ☐ Hispanic ☐		**Email Address:**	
Home #:	**Work #:**		**Cell #:**
Marital Status: S ☐ M ☐ D ☐ W ☐		**Spouse's Name:**	**DOB:**
Is patient residing in a Skilled Nursing Facility/Rehabilitation Center?: Yes ☐ No ☐			
If yes, **Name:**		**Telephone #:**	
Address:	**City:**	**State:**	**Zip Code:**

Emergency Contact Information:

Name:		**Relationship:**
Home#:	**Work #:**	**Cell #:**

Employer Information:

Name:		**Occupation:**	
Address:			**City:**
State:	**Zip Code:**	**Telephone #:**	

Provider Information:

Primary Care Physician:			
Address:			**City:**
State:	**Zip Code:**	**Telephone #:**	

Insurance Information:

- Please have your insurance card(s) and driver's license available for verification.
- Please understand that your insurance card is not a guarantee of payment of any health care claim. Final determination will be made based on your eligibility and benefits at the time of processing.
- Referrals, if required, need to be supplied **before** services are rendered.

Primary Insurance:			**Effective Date:**
Policy ID#:	**Group #:**		
Policy Holder's Name:		**DOB:**	**Sex: M / F**
Relationship to patient: Self ☐ Spouse ☐ Parent/Guardian ☐ Other ☐			
Insurance Address:	**City:**	**State:**	**Zip Code:**
Secondary Insurance:			**Effective Date:**
Policy ID#:	**Group #:**		
Policy Holder's Name:		**DOB:**	**Sex: M / F**
Relationship to patient: Self ☐ Spouse ☐ Parent/Guardian ☐ Other ☐			
Insurance Address:	**City:**	**State:**	**Zip Code:**

Is the reason for your visit related to a work or auto accident? Yes ☐ No ☐

Employment ☐:	**Workers Comp Insurance Carrier:**	
	Date of Accident:	**Claim #:**
Auto ☐:	**Auto Insurance Carrier:**	
	Date of Accident:	**Policy #:**

Whom may we thank for referring you?_____

DATE:_____

PATIENT MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____

Gender: M _____ F _____ Height _____ Weight _____

Occupation: _____

EYE HISTORY

What is/are the main reason(s) for your visit today?

☐ Comprehensive exam - no specific problems
☐ Update eyeglass prescription
☐ Update contact lens prescription
☐ Obtain a second opinion, please explain: _____
☐ Existing eye/vision problem, please explain: _____
☐ Referred by another eye care professional and/or medical doctor
☐ Other: _____

Please circle any applicable symptoms or problems that you have experienced:

BLIND SPOTS	DRY EYE	FOREIGN BODY IN EYE	LIGHT SENSITIVITY
BLURRED VISION	EXCESSIVE TEARING	GLARE	LOW VISION
DISCHARGE	EYE INFECTION	HALOS	REDNESS IN EYE(S)
DISTORTED VISION	EYE PAIN	ITCHINESS	STYE
DOUBLE VISION	FLASHES OF LIGHT	LAZY OR CROSSED EYE	SUDDEN LOSS OF VISION
DROOPY EYE	FLOATERS		

When was the date of your last eye exam?: _____
With Whom?: _____

YES NO ***Do you wear eyeglasses?***
If yes:
How old are your glasses?: _____

Distance	Bifocal	Progressive
Reading	Trifocal	Non-prescription

YES NO ***Do you wear contact lenses?***

Soft	Rigid gas permeable	Cosmetic

YES NO ***Do you sleep in contact lenses?***

How often do you replace your contact lenses?

Daily	1–2 weeks	Monthly	Three Months	Yearly

DATE:_____

Have you ever been previously diagnosed with any of the following?:

☐ Cataract
☐ Diabetic Eye Disease or Retinopathy
☐ Glaucoma
☐ Macular Degeneration
☐ Retinal Disease or Detachment
☐ Corneal problems

Do you have any other eye diseases or vision disorders?:

_____

Have you ever had any eye injuries?:

_____

YES NO ***Have you ever had any previous eye surgeries or laser treatments?***
If yes, which type?

☐ Cataract surgery	☐ Right Eye	☐ Left Eye	Date(s): _____
☐ Eyelid surgery	☐ Right Eye	☐ Left Eye	Date(s): _____
☐ Muscle surgery	☐ Right Eye	☐ Left Eye	Date(s): _____
☐ Retina surgery	☐ Right Eye	☐ Left Eye	Date(s): _____
☐ Laser for glaucoma	☐ Right Eye	☐ Left Eye	Date(s): _____
☐ Laser for diabetes	☐ Right Eye	☐ Left Eye	Date(s): _____
☐ Laser Vision Correction	☐ Right Eye	☐ Left Eye	Date(s): _____
☐ Other: _____	☐ Right Eye	☐ Left Eye	Date(s): _____

MEDICATIONS

Please list all MEDICATIONS that you are currently taking INCLUDING EYEDROPS & VITAMINS

	Medication Name	Strength	How Often		Medication Name	Strength	How Often
1				**8**			
2				**9**			
3				**10**			
4				**11**			
5				**12**			
6				**13**			
7				**14**			

ALLERGIES

YES NO Are you allergic to any medications?
If yes, please list:

_____

YES NO Do you have seasonal allergies?
YES NO Are you allergic to IODINE?
YES NO Are you allergic to LATEX?
YES NO Are you allergic to any foods, dyes, anesthesia, or anything else?
If yes, please list:

_____

DATE:_____

SOCIAL HISTORY

Alcohol Use	*Tobacco Use*	*Illicit Drugs*	*Living Situation*
☐ None	☐ None	☐ Yes	☐ Live alone
☐ Social use only	☐ Former	☐ No	☐ Live with spouse
☐ 1-2 drinks daily	☐ Less than 1 pack per day		☐ Live with family
☐ Above average	☐ More than 1 pack per day		☐ Assisted living or nursing home

FAMILY HEALTH HISTORY

Please check and indicate relationship(s)

☐ Blindness _____
☐ Cancer _____
☐ Cataract _____
☐ Glaucoma _____
☐ Heart Disease _____
☐ High Blood Pressure_____
☐ Macular Degeneration _____
☐ Retinal Detachment _____
☐ Retinal Disorder _____
☐ Other Retinal Problems _____
☐ Other _____

YES NO ***Have you ever taken Flomax® (tamsulosin)?***

If you take blood-thinning medication, when did you last have blood work? _____

YES NO ***Does your medical physician recommend antibiotics prior to surgery and/or dental work?***
If yes, indicate type of antibiotic:

_____

PAST MEDICAL HISTORY

Please circle YES or NO to conditions listed on the next page.
Please list any surgeries, injuries, operations, hospitalizations, and/or other medical conditions here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

DATE:_____

PAST MEDICAL HISTORY
(CIRCLE YES OR NO ON ALL)

Cardiovascular

Y N Heart Disease
*List*_____
Y N Heart Attack
*Date*_____
Y N Angina
Last _____
Y N Stroke
Date _____
Y N High Blood Pressure
Y N High Cholesterol
Y N Pacemaker
Y N Defibrillator
(attach copy of card)
Y N Other Condition?
_____

Endocrine

Y N Diabetes
Date of Diagnosis
_____
Y N (Diet- Controlled)
Y N (Oral Medications)
Y N (Insulin)
Y N (Insulin Pump)
Y N Thyroid
High or Low
Y N Gout
Y N Other Condition?
_____

Gastrointestinal

Y N Ulcers
Y N Colitis
Y N Diverticulitis
Y N Crohn's Disease
Y N Liver Disease
Y N Hepatitis
*Type*_____
Y N Other Condition?
_____

Musculoskeletal

Y N Arthritis
Y N Osteoporosis
Y N Joint Disease
Y N Joint Replaced?
Y N Lupus
Y N Fibromyalgia
Y N Rheumatoid Arthritis
Y N Other Conditions?
_____

Skin Problems

Y N Keloids/ Scarring
Y N Rosacea
Y N Psoriasis
Y N Tumor or Cysts
Y N Other Condition?
_____

Respiratory

Y N Asthma
Y N Emphysema
Y N COPD
Y N Tuberculosis
Y N Sleep Apnea
Y N Pneumonia
Y N Lung Disease
*Type*_____
Y N Other Condition?
_____

Genitourinary Problems

Y N Kidney
Y N Bladder
Y N Prostate
Have you ever used:
Flomax (Tamsulosin)
_____

Neurologic

Y N Seizures/Epilepsy
Y N Convulsions
Y N Alzheimer's
Y N Dementia
Y N Parkinson's
Y N Bell's Palsy
Y N Migraines
Y N Headaches
Y N Multiple Sclerosis
Y N Dizziness
Y N Insomnia
Y N Tremors
Y N Other Condition?
_____

Ear/Nose/Throat

Y N Hearing Loss
Y N Hearing Aids
Y N Sinus Infections
Y N Other Condition
_____

Hematologic

Y N Anemia
Y N Bleed easily
Y N Bruise easily
Y N Bleeding Disorder
Y N Circulatory Problem

Immunologic

Y N Herpes Zoster
Y N Herpes Simplex
Y N HIV/AIDS
Y N Sarcoidosis
Y N Sjögren's
Y N Mononucleosis

Psychiatric

Y N Depression
Y N Anxiety
Y N Bipolar
Y N Schizophrenia
Y N Excessive Stress
Y N Other Condition
_____

Y N Have you traveled outside of the country in the last year?

Where?

_____
_____
_____

Y N Do you have a history of cancer?

Type/Date of Diagnosis?

_____
Y N Chemotherapy?
Y N Radiation?

Y N Have you experienced any sudden weight loss or weight gain?

Y N Were you born prematurely?
How early?
_____

Women Only:

Y N Hysterectomy
Y N Mastectomy
Y N Miscarriage
Y N Are you pregnant?
Y N Breastfeeding?

DATE:_____

REVIEW OF SYSTEMS
(CIRCLE YES OR NO ON ALL)

Cardiovascular	***Constitutional***	***Endocrine***	***Gastrointestinal***
Y N Chest Pain **Y N** Shortness of Breath **Y N** Swelling of the Feet **Y N** Racing Pulse **Y N** Irregular Heart Beat **Y N** Is your blood pressure controlled? What was you last blood pressure? _____	**Y N** Fever **Y N** Weight Loss **Y N** Fatigue **Y N** Loss of Appetite **Y N** Chills **Y N** Night Sweats **Y N** Feel Sick **Y N** Poor Appetite	**Y N** Excess Thirst **Y N** Excessive Urination **Y N** Heat Intolerance **Y N** Cold Intolerance **Y N** Hair Loss **Y N** Dry Skin **Y N** Do you check your blood sugar? **Y N** Is your blood sugar well -controlled? What was your last blood sugar? _____ What was your last 3-month blood sugar (Hemoglobin A1C)? _____	**Y N** Abdominal Pain **Y N** Nausea **Y N** Diarrhea **Y N** Blood Stools **Y N** Stomach Ulcers **Y N** Gastrointestinal Ulcers **Y N** Constipation **Y N** Trouble Swallowing **Y N** Yellow Skin
Genitourinary	***Hematology/Oncology***	***Head, Ears, Nose, & Throat***	***Integumentary***
Y N Pain with Urination **Y N** Blood in Urine **Y N** Bladder Trouble **Y N** Dialysis **Y N** Genital Sores/Ulcers **Y N** Kidney Failure **Y N** Kidney Problems **Y N** Kidney Stones **Y N** Prostatitis **Y N** Testicular Pain **Y N** Urinary Discharge	**Y N** Easy Bruising **Y N** Prolonged Bleeding	**Y N** Hearing Loss **Y N** Sore Throat **Y N** Runny Nose **Y N** Dry Mouth **Y N** Jaw Pain **Y N** Jaw Claudication **Y N** Ear Ache	**Y N** Rash **Y N** Change in Freckle **Y N** Change in Mole **Y N** Skin Sores **Y N** Skin Cancer **Y N** Severe Itching
Musculoskeletal	***Neurologic***	***Respiratory***	
Y N Muscle Aches **Y N** Joint Pain **Y N** Difficulty Laying Flat **Y N** Back Pain	**Y N** Weakness **Y N** Headache **Y N** Scalp Tenderness **Y N** Dizziness **Y N** Paralysis **Y N** Tremor **Y N** Stroke **Y N** Numbness **Y N** Tingling in Body **Y N** Seizures **Y N** Convulsions **Y N** Fainting	**Y N** Wheezing **Y N** Cough **Y N** Coughing up Blood **Y N** Severe Cold **Y N** Frequent Colds **Y N** Difficulty Breathing	

Giliberti Eye & LASER CENTER

HIPAA CONSENT FORM

Consent for Purposes of Treatment, Payment, and Healthcare Options

I consent to the use or disclosure of my protected health information by Giliberti Eye & Laser Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Giliberti Eye & Laser Center. I understand that diagnosis or treatment of me by Orazio L. Giliberti, M.D., Dominick I. Golio, MD. and/or Francesca M. Giliberti, MD. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Giliberti Eye & Laser Center is not required to agree to the restrictions that I may request. However, if Giliberti Eye & Laser Center agrees to a restriction that I request, the restriction is binding on Giliberti Eye & Laser Center and Orazio L. Giliberti, M.D., Dominick I. Golio, MD. and/or Francesca M. Giliberti, MD.
I have the right to revoke this consent, in writing, at any time, except to the extent that Orazio L. Giliberti, M.D., Dominick I. Golio, MD. and/or Francesca M. Giliberti, MD or Giliberti Eye & Laser Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, or healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Giliberti Eye & Laser Center's Notice of Privacy Practices prior to signing this document. The Giliberti Eye & Laser Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of the Giliberti Eye & Laser Center. The Notice of Privacy Practices for Giliberti Eye & Laser Center is also provided at 415 Totowa Road, Totowa, New Jersey and on the Giliberti Eye & Laser Center website at www.laserandeye.com. This Notice of Privacy Practices also describes my rights and the Giliberti Eye & Laser Center duties with respect to my protected health information.

Giliberti Eye & Laser Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Giliberti Eye & Laser Center website, calling the office and requesting a revised copy to be sent in the mail, or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

Giliberti Eye & LASER CENTER

PRIVACY STATEMENT ACKNOWLEDGEMENT FORM

Patient Name: _____
(Print)

Parent or Guardian Name: _____
(Please complete if patient is a minor or not competent)

Signature of Patient: _____ **Date**: _____
(Parent or Guardian)

We often need to contact patients by phone. If you are not available, do you give permission for the physician or the office staff to leave a message on your answering machine or voicemail?

Please initial either '*Yes*' or '*No*' to indicate your response. If '*Yes*', please provide the phone number where we can leave a message.

Yes: _____
Phone Number: _____

No: _____

Please list the name, relationship, and the phone number of each person with whom we are allowed to discuss your medical and financial information. Also, please indicate if we may leave a message on his/her answering machine or voicemail.

Name:	Relationship:	Phone Number:	Message?:

1. _____

2. _____

3. _____

Giliberti Eye
& LASER CENTER

BENEFICIARY NOTICE AND AGREEMENT FORM

My signature on this form assures: (1) that Giliberti Eye & Laser Center may be paid directly by my health plan and, in some cases I may have to pay for my treatment; (2) that I am responsible for my belongings; (3) that I have received a copy of the Giliberti Eye & Laser Center Notice of Privacy Practices.

1) PAYMENT FOR SERVICES

I understand that Giliberti Eye & Laser Center may bill my health plan for the care I receive. It is the patient's responsibility to understand their medical insurance and provide us with a current insurance card at the time of each service. If you have a HMO policy that requires a referral from your primary care physician, you are responsible to provide our office with a valid referral at the time of your visit. I agree that payments from my health plan may go directly to Giliberti Eye & Laser Center. All payments of any insurance deductibles, coinsurance, and co-payments are due when services are rendered, and I know that I may need to pay this before I am treated. **If I should receive the payments, I understand that I will be responsible for paying Giliberti Eye & Laser Center.**

If your insurance carrier does not allow for routine eye care, and your visit is for routine eye care, the patient acknowledges to pay a bill in full. Medicare and other insurance companies will pay only for services that they determine to be "reasonable and necessary" under their contracts. If your insurance carrier determines that a particular service(s) is not reasonable and necessary, it will deny payment for that service(s). If your insurance carrier denies payment, the patient is to be personally and fully responsible for this payment. Your insurance (including Medicare) may deny payments for the following non-covered items: **REFRACTION, ANTERIOR SEGMENT PHOTOGRAPHY, SCHIRMER TESTING, HRT, ORBSCAN, PACHYMETRY, AND OTHER NEWLY DEEMED NON-COVERED ITEMS BY YOUR INSURANCE COMPANY.**

I understand and agree that if my plan does not pay the doctor, I will have to do so. Payment for any unpaid balance must be rendered within 10 days of a bill being sent. I further understand that interest (1.5% monthly) will be added to unpaid amounts that are more than **30 days past due**. Delinquent accounts not paid timely will be charged collection, court, and attorney fees.

I understand that Giliberti Eye & Laser Center will hold me responsible in any one of the following situations:

(1) When I choose to have a service that my health plan covers but I do not obtain the required referral or authorization from my health plan.

(2) When I choose not to use my health plan and agree to pay for services myself.

(3) When my out-of-network health plan does not participate with Giliberti Eye & Laser Center for the services I want or need and I agree to pay for my care myself.

(4) When I receive services that are not covered under my health plan.

If my health plan is subject to ERISA (the Employee Retirement Income Security Act under U.S. law), I agree to have Giliberti Eye & Laser Center act on my behalf to obtain my benefits when Giliberti Eye & Laser Center asks to do so. I understand that I must comply with the policies and procedures set by my employee benefit plan.

2) MY PERSONAL BELONGINGS

I understand that I am responsible for my personal belongings and valuables.

3) THE GILIBERTI EYE & LASER CENTER NOTICE OF PRIVACY PRACTICES

If I would like, I may request a copy of the Giliberti Eye & Laser Center Notice of Privacy Practices by asking a staff member, or downloading it on web at www.laserandeye.com.

DISCLAIMER: FINANCIAL INTEREST OF PHYSICIAN

Public law of the State of New Jersey and the Regulations of the New Jersey Board of Medical Examiners mandate physicians, podiatrists, and all other licensees of the Board of Medical Examiners inform patients of any significant financial interest held in a healthcare service.

Accordingly, please take notice the practitioner in this office does have a financial interest in the following healthcare entity to which patients may be referred:

Optical Department
Laser Center
River Drive Laser and Surgery Center

You may of course seek treatment from a healthcare service provider of your own choice. A listing of alternative healthcare service providers can be found in the classified section of your telephone directory under the appropriate headings.

GILIBERTI EYE & LASER CENTER AGREEMENT

I agree to the following items as defined in the above Giliberti Eye & Laser Center Beneficiary Notice and Agreement Form, in addition to the Disclaimer.

Payment for Services
My Personal Belongings
The Giliberti Eye & Laser Center Notice of Privacy Practices
Disclaimer

I hereby authorize Giliberti Eye & Laser Center to furnish information to my insurance carrier(s) concerning my illness and treatment, and assign to the physician all payments for medical services rendered to my dependents or myself.

My Signature _____ **Date** _____

For health care agent/guardian/surrogate/parent (circle one), I, _____, am the representative for this patient.

Representative's Signature: _____

Address: _____ Phone #: _____
_____

If you are the health care agent or guardian, please attach proof that you can act on behalf of the patient.

_____ _____
Witness Signature/Agency Representative Date

Giliberti Eye & LASER CENTER

Lifestyle Questionnaire

1. Please check the following that apply:

- ☐ I would like to see without glasses.
- ☐ I would like to wake up and see the alarm clock.
- ☐ I would like to read a newspaper or book without glasses.
- ☐ I would like to read labels in a store without glasses.

2. Which hand/eye activities do you enjoy? Check those that apply:

- ☐ Crossword puzzles
- ☐ Painting
- ☐ Cooking
- ☐ Gardening
- ☐ Reading books/magazines
- ☐ Computer work
- ☐ Other_____

3. What recreational activities do you enjoy?

- ☐ Golf
- ☐ Tennis
- ☐ Swimming
- ☐ Other_____

4. After surgery, would you be interest in seeing well **without glasses** in the following situations**?**

Distance vision (driving, golf, tennis, other sports, watching TV)
☐ Prefer no **Distance** glasses. ☐ I wouldn't mind wearing **Distance** glasses.

Mild-range vision (computer, menus, price tags, cooking, board games, items on a shelf)
☐ Prefer no **Mild-range** glasses. ☐ I wouldn't mind wearing **Mild –range** glasses.

Near vision (Reading books, newspapers, magazine, detailed handwork)
☐ Prefer no **Near** glasses. ☐ I wouldn't mind wearing **Near** glasses.

5. Please place an "X" on the following scale to describe your personality as best you can:

[----------I----------]

Easy Going Perfectionist

_____ _____

Signature Date