Patient Registration

Please review and fill all pages in it's entirety.

Patient Name				**Salutation**			
Date of Birth		**Age**		**Sex**		**SS #**	
Address							

Communication					
Preference					
Home Phone #	(732)	**Work Phone #**	(732)	**Extension**	
Cell Phone #	(732)	**Email**			

Information			
Primary Language		**Special Needs**	
Race		**Ethnicity**	
Occupation		**Employer**	

Account Responsible					
Responsible				**Salutation**	
Relationship				**SS #**	
Address					
Home Phone #	(732)	**Work Phone #**	(732)	**Extension**	
Email					

Primary Insurance			
Name		**Group Name**	
ID #		**Group #**	
Address			
Phone		**PAY %**	
Insured		**Date of Birth**	
Copay			

Secondary Insurance					
Name		**Group Name**		**Phone**	
ID #		**Group #**			
Address					
Insured		**Date of Birth**			

Emergency Contact

Sal	**First**	**MI**	**Last**	**Relation**	**Home#**	**Cell#**	**Work#**	**Ext**

Release Of Medical Information – Status		
Name	**Relation**	**Release Status**

Health History

Please review, make necessary changes and supply any missing information.
Date:

Review Of Systems								
Cardiovascular	**NO**	**YES**	**Ears, Nose, Mouth, Throat**	**NO**	**YES**	**Respiratory/Lungs**	**NO**	**YES**
Heart pain			Allergies, Hay fever			Asthma		
High blood pressure			Sinus congestion			Chronic bronchitis		
Vascular disease			Runny nose			Emphysema		
Stomach / Intestines			Post-nasal drip			**Urinary / Reproductive**		
Diarrhea			Coughing			**Skin / Hair / Nails**		
Constipation			Dry throat/mouth			**Neurological**		
Weight loss/gain			**Bones / Joints / Muscles**			Headaches		
Endocrine / Hormonal			Rheumatoid arthritis			Fainting/seizures/stroke		
Thyroid/Other glands			Muscle soreness			**Blood / Circulation**		
Diabetes			**Psychiatric**			Bleeding problems		
Anemia			**Allergic / Immunologic**					
Fever								
Please list any other current illnesses, symptoms or problems:								

Diabetic Information					
Type of Test: (Please circle):	**SMBS: Self Monitoring Blood Sugar test**		**OR**	**HgbA1c: Hemoglobin A1c test**	
Date of Last Recorded Test		**Value**		**Location / Timing**	

Ocular Surgical Information				
Date	**Eye**	**Procedure**	**Surgeon**	**Complications**

Past Medical History
Please list any past medical conditions.

Past / Present Ocular History							
	NO	**YES**	**Date Diagnosed**		**NO**	**YES**	**Date Diagnosed**
Glaucoma				**Blindness**			
Cataracts				**Strabismus**			
Age-Related Macular Degeneration				**Amblyopia**			
Eye Injury				**Diabetes**			
Retinal Disease				**Dry Eye**			

Past / Present Ocular History							
	NO	YES	Date Diagnosed		NO	YES	Date Diagnosed
Other Disease:				Refractive			

	NO	YES		NO	YES	Please explain
Computer usage? How many hours?			Any computer vision problems?			
Do you drive?			Do you have visual difficulty when driving?			

Social History							
	NO	YES	How long & quantity		NO	YES	How long & quantity
Do you use Tobacco products?				Psychological drugs?			
Do you use alcohol?				Caffeinated drinks?			
Please list your Hobbies:							

Family History											
	NO	YES	WHO?		NO	YES	WHO?		NO	YES	WHO?
Glaucoma				Eye Injury				Blindness			
Cataracts				Retinal Disease				Strabsmus			
ARMD				Lupus				Amblyopia			
Diabetes				Heart Disease				High Cholesterol			
Cancer				Hypertension				Kidney Disease			
Blindness				Thyroid Disease				Arthritis			
Other:											

Allergies			
Allergy	Onset Date	Reaction	Severity

Contact Lens History					
Type of contact lenses you currently use (gas permeable, soft daily, extended)			How often do you replace your contacts? (daily, weekly, monthly)		
Average number of hours that you wear your contacts		Number of hours worn today		Wearing Type (daily, extended)	

Medical Alerts
Please list all medical alerts (i.e., Do Not Dilate, epilepsy, DNR / DNI):

OUR OFFICE PROTOCOL MUST BE FOLLOWED!

(1) MASKS ARE NOW OPTIONAL

(2) RETINAL IMAGING AND PHOTOS WILL BE TAKEN AS PART OF YOUR ROUTINE EYE EXAM. IF THERE IS AN UNDERLYING MEDICAL CONDITION AND WE PARTICIPATE WITH YOUR MEDICAL INSURANCE WE WILL BILL IT. YOU ARE RESPONSIBLE FOR THE COPAY.

IF NOT THE FEE IS $36.00

Sight threatening diseases such as glaucoma, macular degeneration, diabetic retinopathy and others often have no outward signs or symptoms, which is why eye exams, including a thorough retinal evaluation, are important to protect vision. In an effort to provide a more thorough eye exam our technician will perform this test. Dr. Kerker or Dr. Spears will review the results during your examination today. The results of this exam will become a part of your permanent patient record.

PLEASE PRINT PATIENT'S NAME HERE

SIGNATURE REQUIRED

Dr. Harvey L. Kerker & Dr. Ivy H. Spears,
Optometric Physicians, L.L.P.
40 Bey Lea Rd. Suite C104
Telephone: 732-349-2020 / 732-341-1070
Fax: 732-341-1652

NJ4186 NJ4354

Dear Patient:

Most of our patients have a type of managed care insurance. Under the same managed care insurance company, plans have large variations depending on the employer who contracted with the insurer. We are providers for many plans, and it is *impossible* for us to know the details and restrictions of every "Insurance Plan".

It is essential that *'you know'* the services that are NOT COVERED by "YOUR INSURANCE PLAN". Referral requirements vary from Plan to Plan.

Should we provide you with the services that are not covered by your insurance, and payment is DENIED by YOUR INSURANCE PLANS, We will bill you and expect payment from you for these services.

Please sign below with today's date to indicate that you assume the responsibilities for the NON-COVERED SERVICES

VERY TRULY YOURS,

Harvey L. Kerker, OD
Ivy H. Spears, OD

TODAY'S DATE: _____

PATIENT NAME (PLEASE PRINT): _____

PATIENT SIGNATURE _____
Or for Minor (Responsible Party):

Npg: 6/06

WHAT IS A REFRACTION?

Refraction is the process by which your eye doctor determines the lens combination that helps you to see the best. Your doctor performs a refraction to determine your distance and near prescriptions. The refraction will also provide information about your eye-muscle balance, focusing strength, and focusing ability.

Medicare Patients: Refraction is not a covered procedure under the Medicare program, but it is one of the most frequent and important tests performed by ophthalmologists and optometrists. Under the Medicare program, the beneficiary is responsible for paying the physician for performing this test. Our fee for the refraction can vary between $25.00 and $75.00, we will collect this at the time of service for all Medicare patients.

Commercial Insurances: Some Insurances that provide routine vision benefits will cover a refraction. We will submit the refraction to your insurance company for you, as they will determine what coverage your contract provides. Should your insurance not include refraction coverage, you will be billed between $25.00 and $75.00.

Patient Signature: _____ Date: _____

Dr. Harvey L. Kerker & Dr. Ivy H. Spears,
Optometric Physicians, LLP

HIPPA PRIVACY

Acknowledgement of Receipt of Privacy Notice

By signing this acknowledgement of Receipt of Notice of Privacy Practices (the "Notice"); I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date listed below.

I understand that the "Location" may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit the Location to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with me regarding vision care services provided by the Location (for example, mailings of exam reminders or information about services/products provided by the Location).

I can be assured that this Location does not sell my personal health information of any kind to a third party for such party's own use. I authorize the Location to submit my vision benefit claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from the Location.

_____ _____

PLEASE PRINT PATIENT NAME DATE

_____

Patient Signature or Patient's Legal Representative