

TODAY'S DATE: \_\_\_\_\_

ACCOUNT \_\_\_\_\_

**PERSONAL INFORMATION**

Name: Mr/Mrs/Ms: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Address: \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Email Address: \_\_\_\_\_  Would you like to receive our newsletter  
Home Phone: (     ) \_\_\_\_\_ Business Phone: (     ) \_\_\_\_\_  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Cell Phone: (     ) \_\_\_\_\_

**CHIEF COMPLAINT**

(Check all that apply)

- |                                      |  |   |   |
|--------------------------------------|--|---|---|
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Poor Night Vision     | <input type="checkbox"/> Night Driving Problems | <input type="checkbox"/> Eyestrain Watching TV  |
| <input type="checkbox"/> Dry Eyes    | <input type="checkbox"/> Poor Driving Vision   | <input type="checkbox"/> Seeing to Sew          | <input type="checkbox"/> Seeing Medicare Label  |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Macular Degeneration  | <input type="checkbox"/> Flashes of Light       | <input type="checkbox"/> Reading Vision Probs   |
| <input type="checkbox"/> Glaucoma    | <input type="checkbox"/> Reading Phone Book    | <input type="checkbox"/> Retinal Problems       | <input type="checkbox"/> Prob. Judging Distance |
| <input type="checkbox"/> Tired Eyes  | <input type="checkbox"/> Color Vision Problems | <input type="checkbox"/> Glare Problems         | <input type="checkbox"/> Family Hist. Glaucoma  |
| <input type="checkbox"/> Floaters    | <input type="checkbox"/> Cataracts             | <input type="checkbox"/> Had Eye Surgery        | <input type="checkbox"/> Itching/Burning Eyes   |

**REVIEW OF SYSTEMS** (Please circle all problems you have. If you have none check "NONE")

- |                   |   |             |                               |                               |
|-------------------|---|-------------|-------------------------------|-------------------------------|
| Head              | Headaches   | Other _____ | <input type="checkbox"/> NONE |                               |
| Ears              | Hearing Loss  | Other _____ | <input type="checkbox"/> NONE |                               |
| Eyes              | Cataracts   | Glaucoma    | Retinal Problems              | <input type="checkbox"/> NONE |
|                   | Eye Muscle Problems   | Lazy Eye    | Other _____                   | <input type="checkbox"/> NONE |
| Nose              | Sinusitis   | Other _____ | <input type="checkbox"/> NONE |                               |
| Throat            | _____ <input type="checkbox"/> NONE   |             |                               |                               |
| Feet              | Pain, Cold, Swelling, Tingling, Sores, Toenail problems _____ <input type="checkbox"/> NONE |             |                               |                               |
| Cardio Vascular   | High Blood Pressure, Heart Disease, Other _____ <input type="checkbox"/> NONE               |             |                               |                               |
| Lungs             | Asthma, Emphysema, Other _____ <input type="checkbox"/> NONE                                |             |                               |                               |
| Gastro-Intestinal | Ulcers, Heartburn, Diarrhea, Other _____ <input type="checkbox"/> NONE                      |             |                               |                               |
| Gastro-Urinary    | Prostate Problems _____ <input type="checkbox"/> NONE                                       |             |                               |                               |
| Endocrine         | Diabetes, Thyroid, Other _____ <input type="checkbox"/> NONE                                |             |                               |                               |
| Extremities       | _____ <input type="checkbox"/> NONE   |             |                               |                               |
| Surgery           | _____ <input type="checkbox"/> NONE   |             |                               |                               |
| Other Medications | _____ <input type="checkbox"/> NONE   |             |                               |                               |
| Allergies         | Penicillin, Sulfa, Hayfever, Other _____ <input type="checkbox"/> NONE                      |             |                               |                               |

**FAMILY HISTORY**

- |                   |                                      |                               |
|-------------------|--------------------------------------|-------------------------------|
| Social History    | Smoking, Drugs, Alcohol, Other _____ | <input type="checkbox"/> NONE |
| Cataracts         | _____                                |                               |
| Glaucoma          | _____                                |                               |
| High Blood Press. | _____                                |                               |

**Do You Experience eye strain while using a computer?**  
 YES

**Would you like more information regarding laser vision correction?**  
 YES

**Would you like more information regarding contact lenses?**  
 YES

When was your last eye exam?

1 2 3 4 5 \_\_\_\_

Months  Years Ago

Primary Care Physician

Phone No.

Whom should we contact in case of emergency?

Phone No.

How were you referred to our office?

How will today's visit be paid?

N/A

Cash

Check

Credit Card

2nd Opinion

All fees for services are due and payable at the time services are rendered. We will assist you in every way possible to help you get reimbursed by your insurance carrier. With my signature below I agree to deliver payment at the time of service, including any balance accrued after insurance is billed and any collection fees.

Our physicians are Medicare Participating Providers. We will bill Medicare & insurance directly and accept assignment. Medicare will pay 80 percent of the Medicare Allowed Charges and you, the patient, are responsible for 20 percent. You are also responsible for your annual Medicare deductible of \$100 and any non-covered service such as lasik which is done in conjunction with an exam. You are responsible for all deductibles, copays and non-covered services.

I request that payment of authorized Medicare benefits be made on my behalf to NJ Eye Center (Joseph Dello Russo, M.D., and affiliated physicians) for any services furnished me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized insurance benefits be made on my behalf to NJ Eye Center (Joseph Dello Russo, M.D., and affiliated physicians) for any services furnished me by them. I authorize any holder of medical information about me to release to my insurance carrier any information needed to determine these benefits or the benefits for related services.

**X**

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

**Please visit our optical shop today for a FREE cleaning and adjustment of your glasses.**

# DELLO RUSSO LASERVISION

## HIPPA Consent

### 1. Acknowledgment of Privacy Practice Notice

I have received a copy of the Dello Russo Laser Vision Notice of Privacy Practices

**Patient's name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient**/Parent/Guardian

\_\_\_\_\_  
**Date**

### 2. Designation of Certain Relatives, Close Friend and Other Caregiver

Initial       Update

I agree that Dello Russo Laser Vision may disclose certain portions of my health information to a family member, close friend and other caregiver because such person is involved with my health care or payment relating to my health care or payment relating to my health care. In that case, Dello Russo Laser Vision will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

**I wish to make no designation at this time**

\_\_\_\_\_  
**Signature of Patient**/Parent/Guardian

\_\_\_\_\_  
**Date**

I designate the following persons listed bellow as persons involved with my health care or payment relating to my health care for the purpose of Dello Russo Laser Vision making the limited disclosures described above. (I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.)

Print Name: \_\_\_\_\_ Last 4 digits of his/her SS# (required) \_\_\_\_\_ {5 times}

Print Name: \_\_\_\_\_ Last 4 digits of his/her SS# (required) \_\_\_\_\_ {5 times}

Print Name: \_\_\_\_\_ Last 4 digits of his/her SS# (required) \_\_\_\_\_ {5 times}

Print Name: \_\_\_\_\_ Last 4 digits of his/her SS# (required) \_\_\_\_\_ {5 times}

\_\_\_\_\_  
**Signature of Patient**/Parent/Guardian

\_\_\_\_\_  
**Date**

# DELLO RUSSO LASERVISION

## PATIENT DISCLOSURE CONSENT

HIPAA privacy rules give individuals the right to request a restriction of uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications be made via alternative means such as sending information to the individual's place of employment instead of their home.

I wish to be contacted in the following manner:

**Home Telephone #** \_\_\_\_\_

OK to leave a detailed message

Leave a message with a callback number only

Ok to speak with spouse, significant other, or family member

**Cell phone #** \_\_\_\_\_

OK to leave a detailed message

Leave a message with a callback number only

Ok to speak with spouse, significant other, or family member

**Alternate Telephone number #** \_\_\_\_\_

OK to leave a detailed message

Leave a message with a callback number only

Ok to speak with spouse, significant other, or family member

Privacy rules require us to take reasonable steps to limit the use or disclosure of your information to the minimum necessary to accomplish the intended purpose. Uses and disclosures are permitted without prior consent in an emergency.

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_