LAKELAND OPHTHALMOLOGY

Parsippany NJ: 973.331.0300
Livingston NJ: 973.588.7005
www.eyedocnj.com

Welcome. Please tell us a little about yourself.

Patient Registration

Today's Date:_____/_____/_____ Primary Care Doctor:_____Phone #_____

Name (last, first, middle):_____Marital Status: _____

Home Address: _____

City:_____State:_____Zip Code: _____

Home Phone # (_____)_____Work # (_____)_____Cell # (_____) _____

Sex: M or F Date of Birth:_____/_____/_____ Age: _____ e-mail: _____

SS #_____(Check One) O Employed O Retired O Student O Other _____

Race:_____ Language:_____ Ethnicity:_____

Employer: _____

Employer Address: _____

Emergency Contact

Name:_____Relationship:_____Phone # (_____) _____

Insurance Information.

Insurance Company: _____

Subscriber (Check One) O Self O Spouse O Parent O Other _____

Name of Subscriber (if other than patient)_____DOB:_____SS#_____

Policy ID #_____Group # _____

Secondary Insurance Company: _____

Please inform us if you have Vision Service Plan (VSP). Yes or NO

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine benefits.

I acknowledge receipt of Lakeland Ophthalmology's Notice of Privacy Practices.

I request that payment of authorized insurance/Medicare benefits be made on my behalf to Lakeland Ophthalmology and/or Lakeland Optical for all assigned claims. I request that payment of authorized insurance/Medicare benefits not assigned be made either to me or on my behalf to Lakeland Ophthalmology and/or Lakeland Optical for any services furnished me by that supplier.

Signature:_____**Date:**_____/_____/_____

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This Authorization form is Optional

Limited Patient Authorization for Disclosure of Protected Health Information

Form 7.31

Please fill in all shaded areas. Form must be signed and dated.

Patient Name:_____ Date of Birth:_____

Entity Requested to Release Information: _____ Lakeland Ophthalmology

Purpose of request (who will be authorized to receive information) - I authorize Lakeland Ophthalmology to disclose or provide protected health information, **about me to the individuals listed below.**

Who can we talk to?

Name:_____ **Name:**_____

Address:_____ **Address:** _____

Phone/Fax:_____ **Phone/Fax:**_____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

□ **Entire patient record;** or**, only the following:** _____

□ **Patient Request** □ **Other (please specify):** _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

- This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____

Patient or authorized representative signature **date**

You have the right to receive a copy of signed authorizations upon request.

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Medical History Questionnaire

Today's Date_____ **Name** _____

Birth Date _____

Do you presently have any problem in these areas? If yes, please explain

Integument (skin)	Yes No	_____
Head	Yes No	_____
Eyes	Yes No	_____
Ears, nose, mouth, throat	Yes No	_____
Neck	Yes No	_____
Bones, joints (arthritis)	Yes No	_____
High Blood pressure	Yes No	_____
Kidney Disease	Yes No	_____
Thyroid Disease	Yes No	_____
Prostate Disease	Yes No	_____
Respiratory (lungs breathing, Asthma, Bronchitis)	Yes No	_____
Cardiovascular (heart/blood vessels)	Yes No	_____
Neurological system (e.g. stroke)	Yes No	_____
Lympharies (lymph nodes, swelling)	Yes No	_____
Hematopoietic (Blood)	Yes No	_____
Allergic and immunologic	Yes No	_____
Infectious (e.g. AIDS, Hepatitis)	Yes No	_____
Psychiatric	Yes No	_____
Diabetes	Yes No	_____
Gastrointestinal (stomach, liver)	Yes No	_____
High Cholesterol	Yes No	_____

Medications you take: name, dosage, how many times a day.
(Include Vitamins, Herbal and over the counter meds)_____

_____

Surgeries and hospitalizations you have had in the past: _____

_____

Major illnesses and/or injuries you have had in the past. _____

_____

Do you have any allergies to medications Yes No _____

Are you allergic to latex? Yes No **Are you allergic to tape? Yes NO**

Are you allergic to shellfish, iodine or iodine preparations? Yes No

Any other allergies?_____

Pharmacy: _____

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Family History:

Name_____

What is the health status or cause of death of your parents, siblings or children?_____

_____

Any diseases in the family? If yes, indicate relationship to patient.

Blindness	Yes	No	_____
Cataract	Yes	No	_____
Glaucoma	Yes	No	_____
Macular Degeneration	Yes	No	_____
Retinal Detachment	Yes	No	_____
Arthritis	Yes	No	_____
Cancer	Yes	No	_____
Diabetes	Yes	No	_____
Heart Attacks	Yes	No	_____
High Blood Pressure	Yes	No	_____
Kidney Disease	Yes	No	_____
Stroke	Yes	No	_____
Thyroid Disease	Yes	No	_____
Other	Yes	No	_____

Social History:

Present Occupation? _____

Do you drink alcohol?	Yes	No	If yes how many glasses a day _____
Do you smoke?	Yes	No	If yes how many pack / cig a day?_____
Do you have an advance Directive /Living Will?	Yes	No	

Do You:

Wear glasses	Yes	No
Wear contact lenses	Yes	No
Bleed excessively	Yes	No
Cough regularly	Yes	No
Have Chest Pain	Yes	No
Get short of breath	Yes	No
Sleep on more than one pillow	Yes	No
Have problems with urine	Yes	No
Have problems with digestion	Yes	No

Primary Care Physician_____**Phone** _____

Referring Physician _____**Phone** _____

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Name:_____ **Dry Eye Disease/Ocular Surface Test Questionnaire**

Have you used eye drops in the last 2-hours Y or N

Please circle the FREQUENCY of your dry eye symptoms

Dryness, Grittiness or Scratchiness	Never[0]	Sometimes[1]	Often[2]	Constant[3]
Soreness or Irritation	Never[0]	Sometimes[1]	Often[2]	Constant[3]
Burning or Watering	Never[0]	Sometimes[1]	Often[2]	Constant[3]
Eye Fatigue	Never[0]	Sometimes[1]	Often[2]	Constant[3]

Please circle the SEVERITY of your dry eye symptoms.

Dryness, Grittiness or Scratchiness	Never[0]	Tolerable[1]	Uncomfortable[2]	Bothersome[3]	Intolerable[4]
Soreness or Irritation	Never[0]	Tolerable[1]	Uncomfortable[2]	Bothersome[3]	Intolerable[4]
Burning or Watering	Never[0]	Tolerable[1]	Uncomfortable[2]	Bothersome[3]	Intolerable[4]
Eye Fatigue	Never[0]	Tolerable[1]	Uncomfortable[2]	Bothersome[3]	Intolerable[4]

Please circle if you have experienced these symptoms:

Today within the past 72 hours within the past 3 months

Do you use eye drops and/or ointments? Y or N Have you used them before? Y or N

Name of drops:_____ How long are they effective?_____

Do the drops last 4 hours? Y or N Do any gels last 12 hours? Y or N

Did you use Moisturizer, lotions or creams around eyes today? Y or N

Did you use makeup today? Y or N

Have you touched/rubbed your eye(s) today? If yes, when? How?

Have you ever been told you have BLEPHARITIS? Y or N STYE? Y or N

Do you have fluctuating vision problems (that gets better with BLINKING)?

for office use only.

TEAR LAB TESTING DONE Y or N

Lakeland Ophthalmology

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is legally required to maintain the confidentiality of your PHI, and to follow specific rules when using or disclosing this information. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules when using or disclosing your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices We are required by law to follow the terms of this Notice. We reserve the right to change the terms of the Notice, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a copy of our current Notice if you call our office and request that a revised copy be sent to you in the mail, or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure - This means we will only use or disclose your PHI as described in this Notice, unless you authorize other use or disclosure in writing. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psy- chotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/ phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI* - This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you will also have the right to request a copy in electronic for- mat. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. We are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the expected date when the request will be fulfilled.

You have the right to request a restriction of your PHI* - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restric- tion. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information* - This means you may sub- mit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability* - You may submit a written request for a listing of dis- closures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

* If you have questions regarding your privacy rights, or would like to submit any type of written request described above, please feel free to contact our Privacy Manager. Contact information is provided at right under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health- care services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appoint- ment. We may contact you by phone or other means to provide results from exams or tests, to provide informa- tion that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain require- ments; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose in- formation to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

You may ask questions about your privacy rights, file a complaint, or submit a written request (for access, restric- tion, or amendment of your PHI or to obtain a disclosure accountability) by notifying our Privacy Manager at:

Lee@eyedocnj.com 973-331-0300 Ext 212

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