Suburban Eye Institute
369 Springfield Avenue
Berkeley Heights, NJ 07922

SUBURBAN EYE INSTITUTE

Account Number

PATIENT REGISTRATION

Patient Name:		**Chief Complaint:**
Salutation: Mr. _____ Mrs. _____ Miss _____ Ms. _____		**Do You Currently Wear Contacts?** Yes _____ No _____
Sex:	**Birth Date:**	**If not:** **Are you interested in Contacts?:** Yes_____ No_____
Marital Status: M _____ S _____ W _____ D _____		**SS #:**

CURRENT ADDRESS	
Address:	
City:	**State & Zip Code :**

COMMUNICATION					
Home Phone #		**Work Phone #**		**Extension**	
Cell Phone #		**Text or Email?**	**Yes _____ No _____**		
Email					

GOVERNMENT REQUIRED INFORMATION **Check One in EACH Section**	
Primary Language	☐ English ☐ Spanish ☐ Other: _____
Race	☐ American Indian or Alaska Native ☐ Black or African American ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other Race ☐ Decline to Answer
Ethnicity	☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown ☐ Decline to Answer

Do you smoke?	Yes _____ No _____	If yes, how much?	
Do you drink Alcohol?	Yes _____ No _____	If yes, how much?	

INFORMATION			
Special Needs		**Occupation**	
Employer		**Employer Address/Phone**	

ACCOUNT RESPONSIBLE					
Responsible Party				**Birth date**	
Pt. Relationship				**SS #**	
Address					
Home Phone #		**Work Phone #**		**Extension**	
Email					

PRIMARY INSURANCE	
Name	**Group Name**
ID #	**Group #**
Address	
Phone	
SECONDARY INSURANCE	
Name	**Group Name**
ID #	**Group #**
Address	
Phone	

Medications Name:	Dosage/Frequency:

Emergency Contact		
Name	**Relationship**	**Phone #**

Consent for Purposes of Treatment, Payment, and Healthcare Operation

Please sign this form when you get to the office

A federal regulation, known as the "HIPAA Privacy Rule", requires that we provide you a detailed notice in writing of our privacy practices. This regulation ensures that you have certain rights to privacy regarding your protected health information.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of this notice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

HIPAA also requires us to address any special needs you may have to assure your patient information is kept confidential. Therefore, please answer the following questions:

□ Yes □ No May we call/text/e-mail you to remind you of your appointment?

□ Yes □ No May we leave a message on your answering machine if you are not available?

□ Yes □ No Do you authorize our office to discuss your health information with another family member (including anyone you may have previously listed)?

If so, whom? _____ Relationship _____

whom _____ Relationship _____

whom _____ Relationship _____

My signature below verifies that I understand that this information will be used to 1) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; 2) Obtain payment from third party payors; 3) Conduct normal healthcare operations such as quality assessments and physician certifications. I have the right to revoke the consent in writing at any time, unless Suburban Eye Institute has already taken action relying on this consent.

Patient's Signature:_____Date: _____

CONTINUE ------>

SUBURBAN EYE INSTITUTE OPTOMETRISTS

Of Berkeley Heights

369 Springfield Avenue Berkeley Heights, N.J. 07922 Phone (908) 464-0123 Fax (908) 665-2936

PATIENT'S NAME_____ TODAY'S DATE_____

DR.'S NAME **(CIRCLE ONE)** ____LUKASZEK_____LYNLY_____MACKEY_____

OFFICE POLICY REGARDING "PAYMENT OF SERVICES"

In order to maintain an optimal relationship between staff and patients and to avoid misunderstandings regarding our payment policies we ask that you read and sign the following;

- If you do not have any insurance or if we do not participate with your current insurance, payment is due in full at time of service.
- Please understand that your insurance card is not a guarantee of payment. You are ultimately responsible for payment on all services regardless of insurance coverage.
- All Co-pays are due at the time of service.
- If we participate with your insurance plan we will submit your claim provided that you will be responsible for any amount that becomes Patient Liability (Included but not limited to co-pays, deductible, co-insurances, contact lens checks, contact lens fittings, material supplies, topography's and refraction's).
- It is your responsibility to know the provisions of your insurance plan.

If referrals are needed for your particular plan it is your responsibility to find out and obtain one. You must then bring it to our office prior to the exam. If the referral is not received before the exam is performed and the claim is rejected the balance of the exam will be the responsibility of the patient.

It is also your responsibility to provide us with your most updated and accurate demographic and insurance information at each visit. Failure to do so may result in the bill becoming your responsibility regardless of insurance coverage.

We thank you for your cooperation in this matter.

Your signature below indicates that you have read, understood and agreed to abide by the above policy.

Signature_____

Date_____

Dr. Laura A. Lukaszek LIC#: 27OA00507100 TPA# TO 00537
Dr. Brenda K. Lynly LIC#27OA00545500 OM# OM-00431
Dr. Brian M. Mackey LIC# 27OM00045400 OM#: OM-00463

Optical Correction of Visual Abnormalities
Diagnosis and Treatment of Ocular Disease
Contact Lenses Orthokeratology

MEDICAL HISTORY

Name:_____
Please indicate whether you or your family member has had any of the following;

AIDS/HIV	You_____ FM____	Headaches	You____ FM____
Amblyopia	You_____ FM____	Heart Disease	You____ FM____
Arthritis	You_____ FM____	Hypertension	You____ FM____
If Yes, what type_____		High Cholesterol	You____ FM____
Asthma	You_____ FM____	Kidney Problems	You____ FM____
Cancer	You_____ FM____	Liver Disease	You____ FM____
Cataracts	You_____ FM____	Psychiatric Care	You____ FM____
Chemical Dependency	You_____ FM____	Retinal Disease	You____ FM____
Diabetes	You_____ FM____	Strabismis	You____ FM____
Epilepsy/Seizures	You_____ FM____	Stroke	You____ FM____
Glaucoma	You_____ FM____	Thyroid Disease	You____ FM____
Macular Degeneration	You_____ FM____		

Other:_____

Surgeries you have had_____

Hospitalizations other than for the surgeries listed_____

Review of Current Symptoms

Please review the following carefully and circle any that you may be experiencing;

Cardiovascular*:* change in temperature of extremity, murmur, pacemaker, shortness of breath, tightness in chest, varicsitiess;

Constitutional: appetite decrease, appetite increase, chills, dizziness, headaches, hot flashes, migraine, night sweats, sleep problems, thirst, vertigo, weight gain, weight loss;

Endocrine; cold intolerance, cuts take longer to heal, dry hair, dry skin, heat intolerance, hyperglycemia, hypoglycemia;

Ear, Nose, Mouth, Throat; bleeding gums, bloody nasal discharge, cough, difficulty with hearing, dry throat and/or mouth, lost sense of smell, painful teeth, post nasal drip, ringing in ears, runny nose, tinnitus;

Eyes: blurred vision, discharge, dry eye, excess tearing/watering, itchy eyes, pain or soreness in or about the eyes, photo sensitivity,reddened eye(s);

Gastrointestinal: abdominal pain, abdominal distention, blood in stool, constipation, diarrhea, excess gas, heartburn, nausea;

Genitourinary: blood in urine, burning with urination, discharge, flank pain, herpes outbreak, impotence, polyuria, urinary frequency, urinary incontinence, urinary urgency

Immunologic: arthritic flare-up, asthma attack recently, coughing, environmental allergies, eyes watering, hay fever symptoms, seasonal allergies;

Integumentary: blisters, burning of skin, dry/scaly skin, eczema, hair loss, hypersensitivity of skin, hypertrophic scars, non healing wounds, psoriatic flare-up, rash, sunburn, tingling sensation;

Lymphatic: anemia, bleeding tendency, bruise easily, fatigue, frequent nose bleeds, increased time to stop bleeding, recent night sweats, swollen lymph nodes, water retention;

Muscular/Skeletal: abdominal pain, back pain, hip pain, joint redness/swelling, leg cramps, morning stiffness, muscle tenderness, stiffness, weakness;

Neurological: burning, facial tick, hypersensitivity, numbness, paralysis, recent seizure, tingling, tremors;

Psychiatric: addiction to alcohol, anger, anxiousness, depression, disorientation, irritability, memory loss, nightmares, panic attacks, paranoia;

Respiratory: breathing difficulty, chest pain w/inspiration, cold-like symptoms, flu-like symptoms asthma attacks, snoring, wheezing, sleep apnea