

New Patient Registration Form

REA_NP_F100

New Pt Packet V11.09.23

Patient Information

Patient Last Name		First Name		Middle Name		Maiden Name	
Address (Street or Box)				City		State	Zip Code
Home Phone Number		Cell Phone Number		Work Phone Number		E-Mail	
Social Security Number	Date of Birth	Assigned Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female		Pronouns <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> He/Him/His <input type="checkbox"/> They/Them/Theirs <input type="checkbox"/> Other: Please specify: _____			
Gender Identity (Check One) <input type="checkbox"/> Identify as Male <input type="checkbox"/> Identify as Female <input type="checkbox"/> Gender Nonconforming/Non-binary <input type="checkbox"/> Other (Please specify) _____ <input type="checkbox"/> Choose not to disclose				Sexual Orientation (Check One) <input type="checkbox"/> Lesbian/Gay/Homosexual <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else, please describe _____ <input type="checkbox"/> Don't Know <input type="checkbox"/> Choose not to disclose			
Marital Status (Check One) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown				Race (Check One) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Other _____			
Ethnicity (Check One) <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino				Employer Name		Employer Address	
Is patient residing in a Skilled Nursing Facility/ Rehabilitation Center? <input type="checkbox"/> Yes <input type="checkbox"/> No				If Yes, Name of Facility		City:	
						Phone Number:	
Primary Care Physician Name				Phone Number			
Emergency Contact & Relationship		Phone Number		Referring Physician Name		Phone Number	

Responsible Party

Complete this section ONLY if Patient is a minor or has a Legal Guardian							
Responsible Party Last Name		First Name		Middle Name		E-Mail:	
Address (Street or PO Box)				City		State	Zip Code
Home Phone Number		Cell Phone Number		Work Phone Number			
Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Other (specify)				Date of Birth		Social Security Number	

Insurance and Subscriber Information

PRIMARY Insurance Company			Effective Date		SECONDARY Insurance Company			Effective Date	
Claims Mailing Address (Street or PO Box)					Claims Mailing Address (Street or PO Box)				
City		State	Zip Code		City		State	Zip Code	
Policy ID Number		Group ID Number			Policy ID Number		Group ID Number		
Subscriber Name (Policy Holder)		Date of Birth			Subscriber Name (Policy Holder)		Date of Birth		
Subscriber Social Security Number		Relationship to Patient			Subscriber Social Security Number		Relationship to Patient		
Subscriber Employer		Work Phone Number			Subscriber Employer		Work Phone Number		
Subscriber Employer Address (Street or PO Box)					Subscriber Employer Address (Street or PO Box)				
City		State	Zip Code		City		State	Zip Code	

Pharmacy

Preferred Pharmacy Name		Pharmacy Address		Pharmacy Phone Number	
Mail-Order Pharmacy Name		Pharmacy Address		Pharmacy Phone Number	

Vision Insurance (if applicable)

Vision Insurance and Subscriber Information

VISION Insurance Company		Effective Date
Claims Mailing Address (Street or PO Box)		
City	State	Zip Code
Policy ID Number	Group ID Number	
Subscriber Name (Policy Holder)	Date of Birth	
Subscriber Social Security Number	Relationship to Patient	
Subscriber Employer	Work Phone Number	
Subscriber Employer Address (Street or PO Box)		
City	State	Zip Code

Signature of Patient, Parent, or Legal Guardian

Date

Consent to Treat and Financial Responsibility

Consent to Treat REA_NP_F101

I hereby authorize employees and agents of Associated Retinal Consultants, LLC ("ARC") dba Ridgewood Eye Associates, an Affiliate of PRISM Vision Group, including physicians, physician assistants, nurse practitioners and other employees and staff members to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency.

Patient Name (Please PRINT)

Signature of Patient, Parent, or Legal Guardian

Date

Complete this section ONLY if patient is a minor or requires a Legal Guardian

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

Signature of Patient, Parent, or Legal Guardian

Date

Financial Responsibility REA_NP_F102

I hereby authorize Associated Retinal Consultants, LLC ("ARC") dba Ridgewood Eye Associates, an Affiliate of PRISM Vision Group, to apply for benefits on my behalf and for payment of medical benefits directly to ARC for services rendered. I request payments of Medicare, Medigap and/or any other insurance company to be made directly to ARC. Authorization is hereby granted to release information contained in the patients' medical record or the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical claim. I understand that I am financially responsible for all charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to ARC.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before services are rendered.

Patient Name (Please PRINT)

Signature of Patient, Parent, or Legal Guardian

Date

Preferred Method of Communication REA_NP_F104

Yes, I want Associated Retinal Consultants, LLC (“ARC”) dba Ridgewood Eye Associates, an Affiliate of PRISM Vision Group, to communicate my information with me through a secure system that is designed to keep my information safe.

My preferred method of communication regarding my medical conditions and/or appointment information is indicated below:

- Home Phone Cell Phone Email Mailed Letter Guardian

If the above method of communication is by **phone**, please do one of the following (**please check ONE**):

- Leave a message with detailed information.
 Leave a message with a call-back number only.

If the above method of communication is by **email**, please consider the privacy implications; for example, any other person that may have access to your e-mail address or any other person, such as your employer, that may have the right and/or ability to review all e-mail received at your work address.

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like us to call you at a different phone number for a specific test result or if you do not want to be contacted at all.

Approved HIPAA Contacts REA_NP_F105

Keeping our patient’s information private is important to us, and by default we will disclose information related to the patient’s Billing Account and Medical Conditions only to the patient or legal guardian.

If you would like to add additional contacts, other than the patient or legal guardian, that Associated Retinal Consultants, LLC (“ARC”) dba Ridgewood Eye Associates, an Affiliate of PRISM Vision Group, is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you listed. If the End Date is left blank, then the duration of this authorization is indefinite unless otherwise revoked in writing.

Contact Name	Relationship to Patient	Contact Phone Number	End Date
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- Billing Account Information** **Medical Condition Information** **Emergency Contact**

Additional Notes: _____

Contact Name	Relationship to Patient	Contact Phone Number	End Date
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- Billing Account Information** **Medical Condition Information** **Emergency Contact**

Additional Notes: _____

Notice of Privacy Practices and Acknowledgement of Receipt

REA_NP_F107

Notice of Privacy Practices and Acknowledgement of Receipt

Patient Name: _____

Date: ____/____/____

The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Associated Retinal Consultants, LLC (“ARC”) dba Ridgewood Eye Associates, an Affiliate of PRISM Vision Group, is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our practice, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations with our Practice. “Protected Health Information” is information about you, including demographic information, that may identify you as well as genetic information, and information that relates to your past, present or future physical or mental health or condition and related health care services.

On ____/____/____ I, _____, received a copy of this office’s Notice of Privacy Practices.
(Today’s Date) (Patient’s Name)

Please Print Name

Signature

Date

* Ridgewood Eye Associates’ Notice of Privacy Practices can also be found on our website: ridgewoodeyeassociates.com.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

This Acknowledgement Form will become part of your permanent medical record.

Medical Questionnaire / Eye History
 REA NP F108

Patient's Name:		Date	/	/
What ocular problem brings you in?				
When was your last eye exam?	/	/	Eye Doctor	
What did your doctor tell you?				

YES NO

Do you wear glasses for vision?					
Do you wear contact lenses?			If so, last time they were changed?		
Do you have Glaucoma?			If so, how is it being treated?		
Have you had cataract surgery?			If so, Which Eye?	Date of Surgery	Name of Surgeon
			Left Eye	/	/
			Right Eye	/	/
Have you had other surgery? <i>Please list details below</i>					

Medical History – Social History

Have you ever suffered from any of the following?

	YES	NO	Comment
Born Prematurely?			
History of Weight Loss, Fever?			
Headaches, Sinus, Tonsillectomy?			
Heart Condition?			
High Blood Pressure?			
Circulatory Problems?			
Lung Disease?			
Ulcers, Liver, Gall Bladder Disease?			
Do you Smoke?			
Do you Drink?			
Kidney, Bladder, Prostate Disease?			

	YES	NO	Comment
Joint Disease?			
Skin Disease or Breast Cancer?			
Stroke or Neurological Disease?			
History of Psychological Disease?			
Thyroid Disease?			
Diabetes?			
Date of Last Blood Sugar Results:			
Bleeding Disorder, Anemia?			
Aids or Infectious Disease?			
Cancer?			

List <u>ALL</u> Medications that you are presently taking, including any eye drops:

List <u>ALL</u> Allergies Including Medications:

FAMILY HISTORY

Is there a family history of	YES	NO	Relative:
Cataracts?			
Glaucoma?			
Retinal Disease?			
Diabetes?			
Hypertension?			
Anemia?			
Other Eye or Systemic Disease?			

Medical History Questionnaire / Review of Symptoms

REA_NP_F109

Patient's Name:	Date / /
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Do you have any problems in the following areas? Please check all applicable

YES NO

YES NO

GENERAL				
Fever				
Fatigue				
Weight Loss / Gain				
Frequent Colds				
EYES				
Blurred Vision				
Double Vision				
Redness				
Sandy or Gritty Feeling				
Blind Spots				
Floaters				
Flashes				
Lazy Eye				
Itching / Burning				
Excess Tearing				
Glare / Light Sensitivity				
Eye Pain				
Chronic Infection Eye / Lid				
ENT: Ears, Nose & Throat				
Sinus Infection				
Cough				
Trouble Walking				
Hoarseness				
Loss of Hearing				
Nose Bleeds				
HEART				
Chest Pain				
Irregular Heart Beat				
Pacemaker				
Heart Murmur				
Swollen Feet / Ankles				
Leg Cramps when Walking				
LUNGS				
Wheezing, Shortness of Breath				
Coughing up Blood / Phlegm				
GI / GU				
Vomiting				
Bloody Bowel Movement				
Heartburn				
Loss of Appetite				
Difficulty with Urination				
Blood in Urine				
Frequent Urination				
Pain in Urination				
MUSCULOSKELETAL				
Muscle Pain				
Joint Pain, Arthritis				
INTEGUMENTARY				
Rash, Bruise Easily				
Breast Disease				
NEUROLOGICAL				
Fainting, Frequent Headaches				
Seizures				
PSYCHIATRIC				
Depression				
Anxiety				
Psychiatric Problems				
ENDOCRINE				
Excessive Thirst				
Excessive Sweating				
HEMATOLOGIC / LYMPHATIC				
Swollen Glands				
ALLERGIC / IMMUNOLOGIC				
Seasonal Allergies				
Hay Fever				
OTHER				
Pregnant				
Menopausal				
Vaginal Bleeding				
Breast Lumps				

COMMENTS REGARDING ABOVE ANSWERS: (PLEASE PRINT)
