

Affiliated Eye Surgeons of Northern NJ, pa

David J Medford, MD

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(973) 732-3322

Mr Mrs Miss Ms _____ **Date** _____

Phone: Home () _____ **Work ()** _____ **Cell ()** _____

Home Address _____

City _____ **State** _____ **Zip** _____

Pharmacy _____ **City** _____ **Phone** _____

Sex: M F Marital Status: Single Divorced Married Widowed Separated

Social Security #: _____ **Date of Birth** ___/___/___

Referred by _____ **Phone** _____

Family Physician _____ **Phone** _____

Your Occupation _____

Your Employer _____ **Phone** _____

Employer's Address _____

City _____ **State** _____ **Zip** _____

Spouse's Name _____

I request that payments from insurance companies in which my doctor participates be made directly to Affiliated Eye Surgeons. I consent that medical information about me may be used or released for the purpose of treatment, payment or healthcare operations to appropriate agencies or to facilitate my claims without my prior written consent or authorization. I understand that while this office may submit the insurance claim on my behalf, the ultimate responsibility for payment of services rendered is mine. I understand further that submission of claims to secondary insurance carriers may be my responsibility if not performed automatically by my primary insurance carrier.

Signed _____ **Date** _____

MEDICAL Insurance — (Primary)

Company Name _____ Policy # _____

Address _____ Group # _____

ARE MEDICAL REFERRALS NEEDED? YES NO Copay \$ _____

Subscriber's Name _____

Subscriber's Date of Birth _____

Subscriber's Social Security # _____

MEDICAL Insurance — (Secondary)

Company Name _____ Policy # _____

Address _____ Group # _____

ARE MEDICAL REFERRALS NEEDED? YES NO Copay \$ _____

Subscriber's Name _____

Subscriber's Date of Birth _____

Subscriber's Social Security # _____

VISION / EYE Insurance (If available)

Company Name _____ Policy # _____

Address _____ Group # _____

ARE MEDICAL REFERRALS NEEDED? YES NO Copay \$ _____

Subscriber's Name _____

Subscriber's Date of Birth _____

Subscriber's Social Security # _____

Name _____ **Birthdate** _____ **Date** _____

	YES	NO		
Do you wear Glasses for vision?	_____	_____	Last changed when?	_____
Do you wear Contacts for vision?	_____	_____	Last changed when?	_____
Do you have Glaucoma?	_____	_____	How many years?	_____
Do you have Cataracts?	_____	_____	How many years?	_____
Have you ever had an EYE INJURY?	_____	_____	Explain?	_____
Have you ever had EYE SURGERY?	_____	_____	For What?	_____
If YES, which EYE? RIGHT _____		Date of surgery _____		Surgeon? _____
LEFT _____		Date of surgery _____		Surgeon? _____

DO YOU SUFFER FROM ANY OF THE FOLLOWING?

	YES	NO	# YRS		YES	NO	# YRS
Hypertension?	_____	_____	_____	Auto-Immune Disease?	_____	_____	_____
Diabetes?	_____	_____	_____	Lung Disease?	_____	_____	_____
Bleeding Disorder?	_____	_____	_____	Cardiac Disorder?	_____	_____	_____
Skin Cancer?	_____	_____	_____	Urinary Problems?	_____	_____	_____
Stroke?	_____	_____	_____	Stomach/GI Problems?	_____	_____	_____
Fever or Chills?	_____	_____	_____	Mental Illness?	_____	_____	_____
Headaches?	_____	_____	_____	Thyroid Problems?	_____	_____	_____
Do you smoke?	_____	_____	_____	Do you drink alcohol?	_____	_____	_____
Other medical conditions?	_____						

Allergies to medication? _____ **Type of reaction?** _____

List ALL Medication—Including Eye Drops and Aspirin

Medication	Dosage/Day	Medication	Dosage/Day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is there any FAMILY HISTORY of:

	YES	NO	Which Relative(s)
Cataracts?	_____	_____	_____
Glaucoma?	_____	_____	_____
Diabetes?	_____	_____	_____
Retinal Disease?	_____	_____	_____
Loss of Vision?	_____	_____	_____

Name _____ Birthdate _____ Date _____

Please list any CHANGES in your medical history and/or medications since your last visit Today's Date: _____

Please list any CHANGES in your medical history and/or medications since your last visit Today's Date: _____

SIGNATURE: _____

Please list any CHANGES in your medical history and/or medications since your last visit Today's Date: _____

SIGNATURE: _____