Cooper River Eye Associates, LLC
6981 N Park Dr, Ste 101, Pennsauken, NJ

Name:_____ **Age:**_____ **Sex:** ☐**M** ☐**F** ☐**NB**
LAST FIRST MI

PATIENT INFORMATION		
Patient Address:_____ **City:** _____ **State:**_____**Zip:**_____		**Home #: (_____) _____ - _____** **Cell #: (_____) _____ - _____** **Work #: (_____) _____ -_____**
DOB		**Marital Status:** ☐Single ☐Married ☐Divorced ☐Widowed
SS#		
Employer		**EMERGENCY CONTACT & PHONE #**
Occupation		
Referred by		
Name of Responsible Party: (☐self)		**Relationship to patient:**
Date of Last Eye Exam:	**Were your eyes dilated? Yes or No**	
Primary Care Doctor:		**Tel.**
EMAIL ADDRESS:	**@**	**@gmail.com @yahoo.com @hotmail.com**

Primary Medical Insurance: _____

PLEASE PROVIDE A COPY OF INSURANCE CARD:

Name of Primary Policyholder:

_____

Date of Birth: ___ / ____ / ____

Relationship of Patient to Policyholder: ☐SELF

☐WIFE ☐HUSBAND ☐CHILD ☐OTHER

Subscriber SS#:_____

Vision Plan (EyeMed/ VSP/ DAVIS / OTHER)

_____

FINANCIAL STATEMENT. Please Read/Sign in order to be examined in our office.

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment.

I understand if I have insurance and have provided accurate and complete information regarding my insurance, my charges will be filed with my insurance carrier; however, the financial responsibility for services rendered to a patient ultimately rests with the patient or responsible party.
I understand that my copay and/or any coinsurance monies are due at the time of service. If I do not have insurance or my charges are not to be filed with insurance, payment in full is due at the time of service. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me, I agree to pay all reasonable attorney's fees and any other court costs or costs of collection. I hereby authorize assignment and payment directly to Cooper River Eye Associates (CREA), LLC any major medical benefits due me for services provided by them.

SIGN_____
Signature of Responsible Party Date

REFRACTION FEE $40. Refraction is a necessary test to determine the prescription for glasses or contacts or to determine if cataract or any other eye disease is limiting your vision from being optimal. Medicare and most medical plans do not cover this fee but many vision plans do cover it.

HIPAA STATEMENT (Protects Patients)

I have read and agree with Cooper River Eyes Associates' ***HIPAA Notice of Privacy Policy.***
I hereby **authorize** Cooper River Eyes Associates to furnish to my insurance company or authorizing agency information regarding my protected health information for the purposes of treatment, payments, or health care operations. I further authorize the physician(s) of CREA to consult as needed in their sole discretion with other medical providers regarding my medical care.

SIGN_____

General Eye/Vision Questions about you

	Y	N
Do you wear eyeglasses?		
What type? Distance **Near** Line Bifocal **Progressive**		
Do you wear contact lenses?	Yes	No
Type/Brand:		
Age of current lenses:		

Ocular (Eye) Questionnaire: Please check Y or N

Are you having problems with:	Y	N
Blurred distance vision		
Blurred near vision		
Sudden loss of vision		
Eye strain while reading or at computer		
Burning * Itch * Discharge		
Grittiness or dryness		
Excessive tearing (watery eyes)		
Double vision		
Eye pain		
Glare * Light sensitivity * Halos		
Floaters or spots in vision		
Flashes of light		
Night vision problems		

Your Personal Eye History

Have you had any eye surgery?	Y	N
Have you had any eye injury?		
Do you have glaucoma or high eye pressure?		
Do you have any cataracts?		
Do you have any macular degeneration?		
If yes or any other eye problems, please explain:		

Family Eye History (Blood relatives only)

Does any blood relative have the following?	Y	N
Glaucoma or high eye pressure		
Macular Degeneration		
Blindness from birth or another reason		
Eye turn or lazy eye		
If yes or any other eye problems, which relative?		

Medical History Questionnaire about you

Do you have any of the following?	Y	N
Diabetes (Type I or Type II)		
High blood pressure (hypertension)		
Heart disease		
Elevated cholesterol		
Asthma or COPD or other breathing problem		
Migraines or other headaches		
Arthritis / Joint pains		
Any type of current or past CANCERS		
Multiple Sclerosis (MS)		
HIV		
Any other Sexually Transmitted Disease		
Female patients: Are you PREGNANT ?		

Additional Medical History Questionnaire

Do you have any other problems with the following systems?	Y	N
Allergic/Immune		
Blood/Lymph		
Cardiovascular		
Ear/Nose/Throat		
Endocrine (glands)		
Gastrointestinal		
Genitourinary		
Mental		
Musculoskeletal		
Nervous		
Respiratory		
Skin		
If yes, please explain:		

Social History and Medicines

	Y	N
Do you smoke any tobacco?		
Do you consume any alcohol?		
Do you consume any other substance(s)?		

LIST ALL YOUR MEDICATIONS:

Are you allergic to any medications ?

If yes, please list below: