MORRISTOWN OPHTHALMOLOGY ASSOCIATES, P.A.
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Health History Questionnaire

First Name _____ MI_____ Last Name_____
Address _____City_____State_____Zip_____
Date of Birth_____ SSN_____ Occupation_____
Gender _____Race _____ Ethnicity_____
Home Phone_____ Work Phone _____Cellphone_____
Email Address _____
Emergency Contact Name_____ Phone Number_____
Primary Insurance Name _____Subscriber_____ _ID# _____
Secondary Insurance Name _____Subscriber_____ ID# _____
Do you have a Vision Plan? Yes/No If so, which one? _____ ID# _____
Referred by_____ Pharmacy & Location_____ Today's Date_____

Medical Information

Main reason for visit _____

Do you have problems with any of these systems? (Please circle Yes or No)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Skin	Yes/No	Headaches	Yes/No
Diabetes	Yes/No	Eyes	Yes/No	Mental	Yes/No
Type 1 or 2_____				High Blood Pressure	Yes/No

Other health problems_____
Allergies? Yes/No Which? _____
Current Medications & Dosage_____
_____
_____
Have you had any major surgeries? Yes/No Type and when? _____
Name of Primary Care Physician_____ Date of last visit_____
Date of last tetanus shot_____ Smoker? Yes/No Former? Yes/No

Family History

High Blood Pressure	Yes/No	Relation_____	Macular Degeneration	Yes/No	Relation_____
Diabetes	Yes/No	Relation_____	Retinal Detachment	Yes/No	Relation_____
Glaucoma	Yes/No	Relation_____	Cataracts	Yes/No	Relation_____

Personal Eye Information

Have you had any eye operations? Yes/No Type _____When_____
Have you had an eye injury? Yes/No Type _____ When_____

Do you have Glaucoma?	Yes/No	Cataracts?	Yes/No	Dry Eyes?	Yes/No
Macular Degeneration?	Yes/No	Retinal Detachment?	Yes/No	Blurred Vision?	Yes/No

Do you have any other eye conditions or problems? Yes/No Explain_____
Do you wear glasses? Yes/No Contact lenses? Yes/No Type_____
Interested in Contact lenses? Yes/No Are you interested in LASIK or Laser Vision Correction? Yes/No

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Protected Health Information

By my signature below, I acknowledge that I have received the *Morristown Ophthalmology Associates, PA* Notice of Privacy Practices.

Printed Name _____ Signature _____

Date of Birth _____

Permission to Release Your Sensitive Information

I, _____, give permission for *Morristown Ophthalmology Associates, PA.,* including the doctors and staff, to speak with the following people about my protected health information (test results, today's appointment, entire medical record, insurance information, billing information, etc.).

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Please Circle:
Is there any information that you would like to be withheld from those listed? Yes/No

If so, what information? _____

Do we have permission to leave detailed voice messages, possibly including sensitive health or billing related information on your phone number(s)? Yes/No

If so, which number(s)? _____

Note: This consent will be in effect until it is revoked in writing.

Signature _____

OR Signature of Parent/Legal Guardian _____

Date _____

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Financial Policy

Responsibility for Payment of Medical Services

I understand it is my responsibility to notify Morristown Ophthalmology Associates, P.A. of my insurance coverage. Any changes to my insurance information after the date of service cannot be resubmitted. Resubmitting the claim becomes the patient's responsibility. I understand that I am ultimately responsible for all fees related to my care.

Co-pays, deductibles, and any non-covered services must be paid at the time of service. Payment will also be due at time of service for any self-pay patients. Morristown Ophthalmology Associates, P.A. will in most cases, file claims for services provided. You are financially responsible if your insurance applies a copay, deductible, and/ or coinsurance to office visits, testing, procedures, or surgery. Identifying the need and obtaining a referral is the responsibility of the patient.

Refraction is the process of determining the eye's refractive error, or need for corrective lenses. However, it is considered a non-covered service by Medicare and most insurance companies: thus, it becomes the responsibility of the patient to pay for the refraction charge, which is collected at the time of the visit.

I understand that if I fail to make any payments for which I am responsible in a timely manner, I will be charged a 2% service charge monthly after 60 days on the remaining balance. I further understand that my account may be turned over for collection and I will be responsible for all costs of collection monies owed, including court costs, collection, and attorney fees. Returned checks will be subject to an additional bank fee of $30.

By completing and signing this form, I authorize the assignment of all health insurance benefits to be paid directly to Morristown Ophthalmology Associates, P.A. and to charge the patient responsibility that is set forth on the Explanation of Benefits from my insurance. Additionally, I authorize Morristown Ophthalmology Associates, P.A. to charge my credit card for co-pays, deductibles, and non-covered services if I leave my credit card on file.

I have read this Financial Policy Authorization Form and agree to the terms and conditions set forth above. I hereby consent to medical care and treatment as deemed necessary and proper by the medical staff of Morristown Ophthalmology Associates, P.A.

_____ _____

Printed Name of Patient or Guarantor Date of Birth of Patient

_____ _____

Signature of Patient or Guarantor Date