EYE ASSOCIATES OF MONMOUTH, LLC

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item**. It is important for your doctor to know that you have carefully reviewed every area of these forms. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Last Name: _____ MI: _____ First Name: _____

☐ MALE ☐ FEMALE MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

Social Security Number (SSN): _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Numbers: HOME: _____ WORK: _____ CELL: _____

Employer: _____ Referred to our office by: _____

Primary Care Physician: _____ Phone Number: _____

Emergency Contact: NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ ID#: _____

Insured Name: _____ Date of Birth: _____ Relationship to Patient: _____

Secondary Insurance Company: _____ ID#: _____

Insured Name: _____ Date of Birth: _____ Relationship to Patient: _____

INSURANCE AUTHORIZATION

I request that payment of authorized Medicare or other insurance companies be made either to me or on my behalf to Dr. Ghobrial for any services furnished. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Signature of Beneficiary Date

_____
Relationship to Patient

Would you like to discuss cosmetic injectables (Botox/Juvederm) with Dr. Ghobrial? YES ____ NO ____
Would you like to discuss laser eye surgery with Dr. Ghobrial? YES ____ NO ____

EYE ASSOCIATES OF MONMOUTH PATIENT PORTAL: By including your email address, you will automatically be sent an email after your appointment with instructions on how to join our Patient Portal which will allow you to access your clinical records and other health information.

_____@_____

PATIENT HEALTH HISTORY

NAME: _____ DATE: _____

WHAT PHARMACY DO YOU CURRENTLY USE? (Please include city and phone number)

_____

ARE YOU TAKING ANY KIND OF MEDICATION NOW? (This includes prescription, over-the-counter or herbal medications.)
☐ NO ☐ YES If yes, please list below.

Name of Medication	Dosage	How often taken?

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ NO ☐ YES If yes, please list below.

Name of Medication	Type of Reaction

NON-MEDICATION ALLERGIES

Are you allergic to any foods? ☐ NO ☐ YES If yes, what foods and type of reaction? _____

Are you allergic to anything that touches your skin? ☐ NO ☐ YES If yes, what are they and what type of reaction?
_____

PAST HEALTH HISTORY

Have you ever been diagnosed with any of the following problems?

Cancer (type) _____ ☐ **NO** ☐ **YES** What year? _____

EYES:
Cataracts ☐ **NO** ☐ **YES** What year? _____
Iritis ☐ **NO** ☐ **YES** What year? _____
Macular Degeneration ☐ **NO** ☐ **YES** What year? _____
Optic Neuritis ☐ **NO** ☐ **YES** What year? _____
Retinal Detatchment ☐ **NO** ☐ **YES** What year? _____
Strabismus ☐ **NO** ☐ **YES** What year? _____

NOSE AND SINUS:
Nasal Allergies ☐ **NO** ☐ **YES** What year? _____

HEART AND BLOOD VESSELS:
High/Elevated Cholesterol ☐ **NO** ☐ **YES** What year? _____
High Blood Pressure ☐ **NO** ☐ **YES** What year? _____

LUNGS AND RESPIRATORY:
Asthma ☐ **NO** ☐ **YES** What year? _____

STOMACH AND DIGESTIVE ☐ **NO** ☐ **YES** What year? _____
Reflux ☐ **NO** ☐ **YES** What year? _____

Hepatitis ☐ **NO** ☐ **YES** What year? _____
Stomach ulcer ☐ **NO** ☐ **YES** What year? _____

KIDNEY AND GENDER:
Renal Failure ☐ **NO** ☐ **YES** What year? _____
Are you pregnant? ☐ **NO** ☐ **YES**

MENTAL AND EMOTIONAL:
Depression ☐ **NO** ☐ **YES** What year? _____
Anxiety ☐ **NO** ☐ **YES** What year? _____

GLANDS, HORMONES, SUGAR CONTROL:
Diabetes ☐ **NO** ☐ **YES** What year? _____
Thyroid Deficiency ☐ **NO** ☐ **YES** What year? _____
Thyroid Excess ☐ **NO** ☐ **YES** What year? _____

BLOOD AND LYMPH NODE:
Anemia ☐ **NO** ☐ **YES** What year? _____

ALLERGIES, IMMUNE SYSTEM, INFECTIOUS:
HIV ☐ **NO** ☐ **YES** What year? _____
Infectious Mononucleosis ☐ **NO** ☐ **YES** What year? _____

SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ **NO** ☐ **YES**
Have you ever been hospitalized for a medical problem? ☐ **NO** ☐ **YES**
If **yes**, please list the reason for admission and the date in which it happened. _____
Have you ever had any form of eye surgery? ☐ **NO** ☐ **YES**
If **yes**, please mark any of the following that you have had:

Cataract Surgery ☐ **NO** ☐ **YES** Which eye? ☐ RIGHT ☐ LEFT DATE(S) OF SURGERY: _____
Glaucoma Surgery ☐ **NO** ☐ **YES** Which eye? ☐ RIGHT ☐ LEFT DATE(S) OF SURGERY: _____
Refractive Surgery ☐ **NO** ☐ **YES** Which eye? ☐ RIGHT ☐ LEFT DATE(S) OF SURGERY: _____

FAMILY HISTORY

No Family History of Significant of Pertinent Health Problems: ☐

Anesthesia Problem: ☐ MOTHER ☐ FATHER ☐ BROTHER ☐ SISTER

HEAD AND FACE:
Headache ☐ MOTHER ☐ FATHER ☐ BROTHER ☐ SISTER

EYES:
Amblyopia (Lazy Eye) ☐ MOTHER ☐ FATHER ☐ BROTHER ☐ SISTER
Glaucoma ☐ MOTHER ☐ FATHER ☐ BROTHER ☐ SISTER
Macular Degeneration ☐ MOTHER ☐ FATHER ☐ BROTHER ☐ SISTER
Retinal Detachment ☐ MOTHER ☐ FATHER ☐ BROTHER ☐ SISTER
Strabismus ☐ MOTHER ☐ FATHER ☐ BROTHER ☐ SISTER

HEART AND BLOOD VESSELS:
Heart Disease ☐ MOTHER ☐ FATHER ☐ BROTHER ☐ SISTER
High Blood Pressure ☐ MOTHER ☐ FATHER ☐ BROTHER ☐ SISTER

LUNGS AND RESPIRATORY:
Asthma ☐ MOTHER ☐ FATHER ☐ BROTHER ☐ SISTER
Lung Cancer ☐ MOTHER ☐ FATHER ☐ BROTHER ☐ SISTER

BRAIN AND NERVOUS SYSTEM:
Stroke ☐ MOTHER ☐ FATHER ☐ BROTHER ☐ SISTER

BLOOD AND LYMPH NODE:
Bleeding/Clotting ☐ MOTHER ☐ FATHER ☐ BROTHER ☐ SISTER

SOCIAL HISTORY

What is your current occupation? _____ Check here if you are retired ☐

Have you ever used tobacco in any form? ☐ NO ☐ YES
If **yes**, please complete the following:

Type of Tobacco	From Year...	...To Year
Cigarettes per day: _____		
Other (List Type): _____		

Have you ever used alcohol in any form? ☐ NO ☐ YES
If **yes**, please complete the following:

Type of Alcohol	From Year...	...To Year
Beers per week: _____		
Wine glasses per week: _____		
Other (List Type): _____		

REVIEW OF SYMPTOMS: **MARK** ANY PROBLEMS YOU HAVE OR HAVE HAD RECENTLY FROM THE FOLLOWING:

GENERAL HEALTH ☐ NO ☐ YES
☐ fever ☐ sleeping problems ☐ unintentional weight loss

HEAD OR FACE ☐ NO ☐ YES
☐ headaches ☐ face pain ☐ face drooping

EYE PROBLEMS ☐ NO ☐ YES
☐ blurred vision ☐ double vision ☐ glare
☐ loss of vision ☐ painful eye ☐ red eye
☐ spots or specks ☐ wandering eye

NOSE AND SINUS ☐ NO ☐ YES
☐ frequent colds ☐ freq runny nose ☐ itchy nose
☐ sinus drainage

NECK ☐ NO ☐ YES
☐ neck masses or lumps ☐ pain ☐ swollen glands

HEART OR CIRCULATION ☐ NO ☐ YES
☐ fainting ☐ bluish color of lips or nails
☐ chest pain ☐ irregular heartbeats
☐ leg cramps ☐ swelling ankles

LUNG OR RESPIRATORY ☐ NO ☐ YES
☐ freq non-productive cough ☐ freq productive cough
☐ shortness of breath ☐ wheezing

BONES, JOINTS, MUSCLES ☐ NO ☐ YES
☐ pain in back ☐ painful joints ☐ stiffness
☐ swelling joints

BRAIN OR NERVOUS SYSTEM ☐ NO ☐ YES
☐ change in alertness ☐ loss of consciousness
☐ numbness ☐ seizures ☐ weakness

GLANDS, HORMONES ☐ NO ☐ YES
☐ feel cold all the time ☐ feel hot when others aren't
☐ increased appetite ☐ increased fatigue
☐ neck has enlarged ☐ unwanted weight change

BLOOD OR LYMPH NODES ☐ NO ☐ YES
☐ excessive bleeding after injury ☐ bruises easily

ALLERGIES ☐ NO ☐ YES
☐ food intolerances ☐ frequent sneezing
☐ hives ☐ post nasal drainage
☐ severe reaction to insect bites

410 Route 34, Suite 218
Colts Neck, NJ 07722
(t): 732-431-6688
(f): 732-431-2552

Authorization for Disclosure of Protective Health Information

Our office reserves the right to leave messages on your answering machine regarding your appointment and/or billing issues, if our attempts to speak with you personally have failed.

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:

☐ MYSELF ONLY
☐ MY SPOUSE, SIGNIFICANT OTHER, OR PARENT (specify name): _____
☐ OTHER (specify name): _____

Please check your choice on information to be disclosed

☐ NO, I do not want medical information to be left on my answering machine.
☐ YES, I give my permission for medical information to be left on my answering system.

If yes, please check the following you would like to receive via answering system:

- ☐ Lab/Test Results
- ☐ Diagnosis
- ☐ Prescriptions
- ☐ Billing

I, _____, have received a copy of this office's Notice of Privacy Practice.
(Please Print Patient's Name)

I understand I have the right to revoke this authorization in writing to the office manager at the address listed above.

I understand that disclosed information pursuant to this authorization may no longer be protected by the federal HIPAA Privacy rule or State law.

_____ _____
Signature of patient or personal representative Date

_____ _____
Printed name of patient or personal representative Date

_____ _____
Relationship of personal representative to patient Date

410 Route 34, Suite 218
Colts Neck, NJ 07722
(t): 732-431-6688
(f): 732-431-2552

FINANCIAL POLICY

We are committed to providing you with the best possible care and are willing to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask us if you have any questions about our fees, financial policy, or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR.

- COPAYMENTS – By law, we MUST collect your carrier designated copay at the time of service. Please be prepared to pay that copay at each visit.

- NON-COPAY PLANS – If your plan does not require a copay and we participate, we will accept the designated fee. You are responsible for any deductible, co-insurance, and balance your plan indicates on your explanation of benefits.

- REFERRALS – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOUR APPOINTMENT WILL HAVE TO BE RESCHEDULED.

- NON PLAN PATIENTS – Payment is expected at the time of your service unless other financial arrangements have been made prior to your visit. Your itemized receipt should be attached to your insurance form and sent to your carrier (if applicable).

- MEDICARE – We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the deductible and the 20% co-insurance,which can be billed to a secondary insurance if you have one.

PATIENT RESPONSIBILITY: I realize that I am responsible for my copay plus any deductible or amount indicated on my explanation of benefits as patient responsibility. I am aware that there is **a $25 fee** for all returned checks. I realize that if my account is unpaid, I will be sent past due and final notices. If there is no response within 10 days, I understand that I will be referred to an outside collection agency. If my account is sent to collections, I realize that I will be assessed a **30% administrative fee** in addition to my outstanding balance.

THANK YOU for taking the time to review our policies.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE