

PATIENT RECORD FORM – PLEASE PRINT

New patient fill form completely

Returning patient update name and any changes

Name: _____ M / F _____ age _____
(FIRST NAME) (LAST NAME) (gender) (birth date)

Address: _____
(city) (state) (zip)

Home Phone: () _____ Work: () _____ Email: _____

Occupation: _____ Employer _____

Our office accepts some insurance plans. We will make every effort to obtain eligibility for you. However, there are times we cannot determine coverage due to factors beyond our control. Please advise us of any insurance changes. You are expected to pay if coverage cannot be verified and/or if any insurance claim is denied for any reason.

New and returning patients please fill out below.

Contact Lens Services

Our office policy is to perform yearly contact lens exams to assess eye health and appropriate lens characteristics. The professional fee for these services are between \$70 and \$150 in addition to the eye exam fee. (Insurance coverage variable)

- I'm here for my yearly contact lens exam and to renew my contact lens prescription.
- I would you like to discuss wearing contacts with the doctor.
- I am not interested in contact lenses.

Computer Users

Our doctors can discuss computer glasses with you that can relieve eye strain.

Do you use a computer several hours per day?

Do your eyes get tired when working on the computer?

Do you get headaches or neck and back pain with computer use?

Please ask if computer glasses would be appropriate for you. ☺

Reason for today's visit: _____

► How did you choose our office?

- walk-in
- word of mouth
- phonebook
- advertisement
- icareassociates.com
- family members
- returning patient

Patient _____ Age _____ Technician _____ DR. _____

Date _____ Appt _____ WI _____ Time _____ Last Exam _____

VA Old Rx: _ Spec _ CL R 20/ L 20/ VA No Rx: R 20/ L 20/ COLOR: _ Normal _ Missed: _____

autoref R _____ NCT od _____ DEPTH PERCEPTION: _____ BP: _____ / _____

L _____ NCT os _____ OPTOS PHOTOGRAPHY DFE : _ Yes _ No

C/C : _____ additional complaint: _____

HPI Location _____ duration _____

timing _____ severity _____

Medical History & ROS from _____ / _____ / _____ reviewed: no changes Dr. Initials _____

Head/Face nl Psych: Mood/Affect (anxiety/agitation/depression) nl Neuro Oriented (person/time/place) y n

Rx 1 OD _____ Rx 2 OD _____ / _____ X _____

OS _____ OS _____ / _____ X _____

Ret OD _____ 20/ subj OD _____ 20/

OS _____ 20/ OS _____ 20/

Add: OD + _____ 20/ OU 20/ X CYL: NRA: + PRA: - CVF nl

OS + _____ 20/ FDT nl

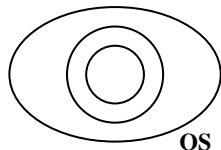
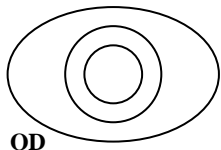
Binocular testing: orthoP EP XP PUPILS: round ou size od _____ APD - +
Other: equal os _____

SLE OD OS
 nl TBUT _____ TEAR FILM nl TBUT _____
 nl Arcus CORNEA nl Arcus
 nl Pterygium nl Pterygium
 nl rubeosis IRIS nl rubeosis
 nl SCLERA nl
 nl Injection CONJ. nl Injection
 nl Pinguecula nl Pinguecula
 D&Q A/C D&Q
 clear nuclear LENS clear nuclear
 AC PSC AC PSC

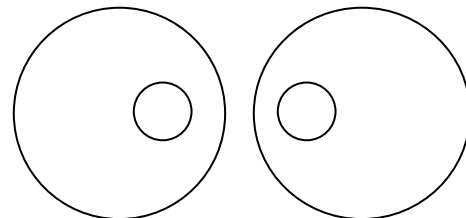
OD OS
_____ C/D _____
 nl _____ size/appearance/nfl nl _____
 nl _____ vessels nl _____
 nl PVD vitreous nl PVD
 nl drusen Macula nl drusen
 nl RPE chngs nl RPE chngs
 nl Periphery nl

Paremyd Dil M .5% 1% N 2.5% OU @ _____

BIOMICROSCOPY / EXTERNAL: Angles: OD OS Goldmann: OD OS



nl LIDS nl
Blepharitis
Meibomianitis



OD OS

FINAL Rx: SPH CYL AXIS PRISM BASE ADD / TYPE

OD _____

OS _____

Additional Tests / Notes:

Pachymetry OD _____ OS _____

PRIO add OD _____ OS _____

DIAGNOSIS / PLAN:

ORDER:

A: _ myopia _ hyperopia _ astigmatism _ presbyopia _ CL fit P: _ Rx given _ PT refused DFE E S/S RD Doctor _____

PATIENT HISTORY as of ____/____/____ (today's date)

Name: _____ Date of Birth: ____/____/____

Physician: Dr. _____
 _____ City _____ phone _____

Medications: _____

Allergies: _____

List all eye surgeries, injuries, severe eye infections and approximate dates:

<i>Current Eye problems</i>	No	Yes	Eye				No	Yes	Eye		
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Right	Left	Both	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Right	Left	Both
Halos/Glare	<input type="checkbox"/>	<input type="checkbox"/>	Right	Left	Both	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Right	Left	Both
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	Right	Left	Both	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Right	Left	Both
Discharge from eyes	<input type="checkbox"/>	<input type="checkbox"/>	Right	Left	Both	Redness	<input type="checkbox"/>	<input type="checkbox"/>	Right	Left	Both
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Right	Left	Both	Burning	<input type="checkbox"/>	<input type="checkbox"/>	Right	Left	Both
Tearing	<input type="checkbox"/>	<input type="checkbox"/>	Right	Left	Both	Light sensitive	<input type="checkbox"/>	<input type="checkbox"/>	Right	Left	Both
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Right	Left	Both	Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	Right	Left	Both

Sensitive to: pollen dust wind pet hair smoke heaters computer use air conditioning

Tell your doctor if any conditions listed below apply to you or your family.

(check yes or no for each)

<u>EYES</u>	<u>Self</u>			<u>CONDITIONS</u>	<u>Self</u>		
	NO	YES	Family		NO	YES	Family
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corneal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keratoconus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Tumor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/ Sinus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/ Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Sjogren's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Raynaud's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Immune Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Smoking	<input type="checkbox"/>	<input type="checkbox"/>	if yes ____ years
				Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	

REVIEW OF SYSTEMS

Any problems with:

	No	Yes
Allergic/Immunologic(infections)	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (skin/rashes/scars)	<input type="checkbox"/>	<input type="checkbox"/>
Neurological(seizures/stroke)	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine(hormone/glands)	<input type="checkbox"/>	<input type="checkbox"/>
Hematological/Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorders(anemia)	<input type="checkbox"/>	<input type="checkbox"/>
Ears,Nose, Mouth, Throat	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular(heart/vessels)	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory(asthma/bronchitis)	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal(stomach/intestine)	<input type="checkbox"/>	<input type="checkbox"/>

► Many sexually transmitted diseases result in eye problems. Discuss any concerns with the Doctor.

Early detection of eye disease is crucial in preventing vision loss and blindness. An evaluation that includes examination of the retina can aid in diagnosing conditions such as retinal holes, retinal detachments, glaucoma, macular degeneration, tumors and diabetic retinopathy, all which can cause vision loss. Additionally, systemic diseases such as high blood pressure can be detected during a retinal exam. Because we continuously strive to provide our patients the very best in eye care services, we offer the following two (2) tests:

Optos[™] retinal scan – Our ability to view your internal eye health is now dramatically improved with the Optos. The Optos retinal evaluation provides:

- A fast, easy, and comfortable annual eye wellness scan
- An in depth view of the retinal layers (where disease can start)
- The ability to review your images with you today
- A permanent record and baseline for your medical file, which gives your doctor comparisons for tracking and diagnosing potential eye disease
- Does not require dilating drops or additional waiting time.

QuantifEYE[®] – Age-Related Macular Degeneration (AMD) is a leading cause of blindness in adults. Its effects are both permanent and irreversible, and there is no adequate treatment; however, it may be managed if caught early. We can now take measures to reduce your risk of developing this disease. The **QuantifEYE** test is a light response test that only takes a few minutes and allows the doctor to determine the effectiveness of your eye’s macular energy absorbing layer. The **more** light energy your eye can absorb the **lower** the risk for macular degeneration.

Please be aware of your risk factors for macular degeneration:

If you are a smoker (even if you have quit), your age, if you are female, have light eyes and/or skin, are light sensitive, and if you don’t eat enough green, leafy vegetables, you may have a higher risk. Also, your risk increases if you or your family have a history of Glaucoma, Cataracts, High Blood Pressure, Diabetes, and Heart Disease.

We strongly recommend that all our patients 21 and older take this test so we can assess your risk for Macular Degeneration, and develop a base-line measurement that allows us to track any changes that might occur in the future. Since this is a new test, never before available, it is not covered by your insurance; however, the cost to you is minimal.

Because your insurance is designed to cover only a basic eye exam, it does not cover advanced screening tools such as the **Optos retinal scan** and **QuantifEye** tests. The doctors at **EyeCare Associates** would like for **ALL** of our patients to have these exams annually. Should you have any questions about either exam, please do not hesitate to ask.

QuantifEYE test: \$35.00 The **Optos** retinal scan: \$49.00 Both procedures together: \$69.00

Optos[™] — The doctor prefers the Optos retinal scan for a thorough retinal evaluation.

Accept Decline

QuantifEYE[®] – I understand my risk factors for Macular Degeneration and choose to: Accept Decline

 Patient Signature

 Date

FOR OFFICE USE ONLY

Pt. Name:_____

MPOD score:_____

0.00 - .24 .25 - .44 .45 and above

Higher risk Mid range Lower risk

- Vitamin Supplements recommended
- Pt. scheduled for 6 months follow up

- Good graph with nice “V” curve
- Had to retest
- Problems with test taking
- Explain any problems with test taking_____

Doctor’s initials_____

 Tech initials_____

**Jim I. Ciccarello O. D.
& Eyecare Associates, P. C.**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. In the event we make a material change in our privacy practices, we will change this Notice and provide it to you. You may also request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations.

Treatment: We may use or disclose your health information to an optician, ophthalmologist or other healthcare provider providing treatment to you. For example, we may use and disclose "protected health information", ("PHI" hereafter) when you need a prescription or when you need to be referred to a specialist for consultation. Prescription information may be given to another optician, ophthalmologist, other healthcare provider or pharmacy.

Payment: We may use and disclose your health information to obtain payment for services provided to you. Generally, we may use and give medical information to others to bill and collect payment on services rendered. Before a patient receives scheduled services, we may share information about these services with your health plan(s), to obtain eligibility information and/or to get the required preapproval. We may also share information with the you health plan(s) once services are rendered and the appropriate health insurance claims must be filed.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include things such as quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Without Your Authorization: We may use and disclose PHI about you under a number of circumstances without your consent or without your right to object. Those circumstances include:

- When use or disclosures are required by law (i.e. federal, state or local law or other judicial or administrative proceedings).
- When the use or disclosure is necessary for public health purposes, (i.e. if you have been exposed to a communicable disease or may otherwise be a risk to the community).
- When the disclosure relates to abuse, neglect or domestic violence.
- When the disclosure relates to decedents (i.e. coroner or medical examiner) or for organ donation.
- When the use or disclosure is for medical research.
- Lastly, when the use or disclosure is needed for an emergency.

With Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Marketing Health Products or Services: We will not use your health information for marketing communications without your prior written authorization. We may provide you with information regarding products or services that we offer related to your health care needs. We will never sell your health information without your prior authorization.

Disclosing Healthcare Information to you or a Third Party: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so or, if you are not able to agree, if it is necessary in our professional judgment.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up prescriptions, contact lenses or other similar forms of health information.

Appointment Reminders and Treatment Alternatives: We may use or disclose your health information to provide you with appointment reminders or routine exam reminders (such as voicemail messages, postcards, or letters) or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

PATIENT RIGHTS

Access: You have the right to review or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to or receive copies of your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may submit your request to the address at the end of this Notice. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Please feel free to contact us using the information listed at the end of this Notice for a full explanation of our fee structure. There are certain circumstances in which we are not required to comply with your request. We will respond to you in writing stating why we will not grant your request and describing and rights you may have to request review of our denial.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, where you have provided an authorization and certain other activities, for the last 6 years, but not for disclosure made prior to April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form as well, per your request.

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.

Contact Person: Privacy Officer
Telephone: (609) 520-1008
Fax: (609) 520-9279

Address: Jim I. Ciccarello, O. D.& Eyecare Associates, P. C.
Princeton Market Fair, Suite 400
3535 U.S. Route One
Princeton, NJ 08540

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I read and received a copy of Jim I. Ciccarello O.D. & Eyecare Associates, P.C.'s Notice of Privacy Practices.

Patient Name: _____ (Please Print)

Signature: _____ Date: _____

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.
- Communication barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgment.
- Other: _____

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