DELLO RUSSO
LASERVISION
1-201-384-7333

1 N. Washington Ave.
Bergenfield, NJ 07621

❑ NEW PATIENT
❑ UPDATE

Be sure to complete BOTH sides
Please have your insurance cards ready
We hope you enjoy your visit today

TODAY'S DATE: _____ **ACCOUNT** _____

PERSONAL INFORMATION

Name: Mr/Mrs/Ms: _____ **Birthdate:** _____
Address: _____ **Social Security #** ____-____-____
City: _____ **State:** _____ **Zip Code:** _____
Email Address: _____ ❑ **Would you like to receive our newsletter**
Home Phone: ( ) _____ **Business Phone:** ( ) _____
Employer: _____ **Address:** _____
Cell Phone: ( ) _____

CHIEF COMPLAINT *(Check all that apply)*

❑ Poor Vision	❑ Poor Night Vision	❑ Night Driving Problems	❑ Eyestrain Watching TV
❑ Dry Eyes	❑ Poor Driving Vision	❑ Seeing to Sew	❑ Seeing Medicare Label
❑ Diabetes	❑ Macular Degeneration	❑ Flashes of Light	❑ Reading Vision Probs
❑ Glaucoma	❑ Reading Phone Book	❑ Retinal Problems	❑ Prob. Judging Distance
❑ Tired Eyes	❑ Color Vision Problems	❑ Glare Problems	❑ Family Hist. Glaucoma
❑ Floaters	❑ Cataracts	❑ Had Eye Surgery	❑ Itching/Burning Eyes

REVIEW OF SYSTEMS (Please circle all problems you have. If you have none check "NONE")

Head	Headaches Other _____	❑ NONE
Ears	Hearing Loss Other _____	❑ NONE
Eyes	Cataracts Glaucoma Retinal Problems	❑ NONE
	Eye Muscle Problems Lazy Eye Other _____	❑ NONE
Nose	Sinusitis Other _____	❑ NONE
Throat	_____	❑ NONE
Feet	Pain, Cold, Swelling, Tingling, Sores, Toenail problems _____	❑ NONE
Cardio Vascular	High Blood Pressure, Heart Disease, Other _____	❑ NONE
Lungs	Asthma, Emphysema, Other _____	❑ NONE
Gastro-Intestinal	Ulcers, Heartburn, Diarrhea, Other _____	❑ NONE
Gastro-Urinary	Prostate Problems _____	❑ NONE
Endocrine	Diabetes, Thyroid, Other _____	❑ NONE
Extremities	_____	❑ NONE
Surgery	_____	❑ NONE
Other Medications	_____	❑ NONE
Allergies	Penicillin, Sulfa, Hayfever, Other _____	❑ NONE

FAMILY HISTORY

Social History	Smoking, Drugs, Alcohol, Other _____	❑ NONE
Cataracts	_____	
Glaucoma	_____	
High Blood Press.	_____	

Do You Experience eye strain while using a computer?
❑ **YES**

Would you like more information regarding laser vision correction?
❑ **YES**

Would you like more information regarding contact lenses?
❑ **YES**

TURN OVER PLEASE →

When was your last eye exam? 1 2 3 4 5 ____ ❒ Months ❒ Years Ago

Primary Care Physician Phone No.

Whom should we contact in case of emergency? Phone No.

How were you referred to our office?

How will today's visit be paid? ❒ N/A ❒ Cash ❒ Check ❒ Credit Card ❒ 2nd Opinion

All fees for services are due and payable at the time services are rendered. We will assist you in every way possible to help you get reimbursed by your insurance carrier. With my signature below I agree to deliver payment at the time of service, including any balance accrued after insurance is billed and any collection fees.

Our physicians are Medicare Participating Providers. We will bill Medicare & insurance directly and accept assignment. Medicare will pay 80 percent of the Medicare Allowed Charges and you, the patient, are responsible for 20 percent. You are also responsible for your annual Medicare deductible of $100 and any non-covered service such as lasik which is done in conjunction with an exam. You are responsible for all deductibles, copays and non-covered services.

I request that payment of authorized Medicare benefits be made on my behalf to NJ Eye Center (Joseph Dello Russo, M.D., and affiliated physicians) for any services furnished me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized insurance benefits be made on my behalf to NJ Eye Center (Joseph Dello Russo, M.D., and affiliated physicians) for any services furnished me by them. I authorize any holder of medical information about me to release to my insurance carrier any information needed to determine these benefits or the benefits for related services.

X _____ _____

PATIENT SIGNATURE DATE

Please visit our optical shop today for a FREE cleaning and adjustment of your glasses.

DELLO RUSSO LASERVISION

HIPPA Consent

1. Acknowledgment of Privacy Practice Notice

I have received a copy of the Dello Russo Laser Vision Notice of Privacy Practices

Patient's name: _____ **DOB**: _____

_____ _____

Signature of Patient/Parent/Guardian **Date**

2. Designation of Certain Relatives, Close Friend and Other Caregiver

[ ] Initial [ ] Update

I agree that Dello Russo Laser Vision may disclose certain portions of my health information to a family member, close friend and other caregiver because such person is involved with my health care or payment relating to my health care or payment relating to my health care. In that case, Dello Russo Laser Vision will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

[ ] **I wish to make no designation at this time**

_____ _____

Signature of Patient/Parent/Guardian **Date**

I designate the following persons listed bellow as persons involved with my health care or payment relating to my health care for the purpose of Dello Russo Laser Vision making the limited disclosures described above. (I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.)

Print Name:_____ Last 4 digits of his/her SS# (required) _____ {5 times}
Print Name:_____ Last 4 digits of his/her SS# (required) _____ {5 times}
Print Name:_____ Last 4 digits of his/her SS# (required) _____ {5 times}
Print Name:_____ Last 4 digits of his/her SS# (required) _____ {5 times}

_____ _____

Signature of Patient/Parent/Guardian **Date**

DELLO RUSSO
LASERVISION

PATIENT DISCLOSURE CONSENT

HIPAA privacy rules give individuals the right to request a restriction of uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications be made via alternative means such as sending information to the individual's place of employment instead of their home.

I wish to be contacted in the following manner:

Home Telephone #_____

OK to leave a detailed message
Leave a message with a callback number only
Ok to speak with spouse, significant other, or family member

Cell phone #_____

OK to leave a detailed message
Leave a message with a callback number only
Ok to speak with spouse, significant other, or family member

Alternate Telephone number #_____

OK to leave a detailed message
Leave a message with a callback number only
Ok to speak with spouse, significant other, or family member

Privacy rules require us to take reasonable steps to limit the use or disclosure of your information to the minimum necessary to accomplish the intended purpose. Uses and disclosures are permitted without prior consent in an emergency.

Patient signature: _____ **Date:** _____