COHEN EYE INSTITUTE

28 Throckmorton Lane
Old Bridge, NJ 08857
732-679-6100

PLEASE PRINT **DATE**_____

PATIENT'S NAME _____

DATE OF BIRTH _____**MALE** _____ **FEMALE** _____

HOME ADDRESS _____

CITY, STATE, ZIP _____

HOME PHONE _____ **WORK #**_____**CELL#** _____

Would you like to be notified only for recall exams by email? YES _____ **NO** _____

EMAIL ADDRESS _____

PAYMENT WILL BE MADE TODAY BY: Cash _____**Check** _____**Credit Card** _____

PATIENT'S SOCIAL SECURITY # _____

PT. EMPLOYER _____**PHONE** _____

BUSINESS ADDRESS_____

OCCUPATION _____

SPOUSES NAME _____

SPOUSES EMPLOYER _____

REFERRED BY DR. _____

PRIMARY INSURANCE _____

POLICY # _____**GROUP #**_____

SECONDARY INSURANCE _____

POLICY # _____**GROUP #**_____

OTHER INSURANCE _____

SUBSCRIBER'S NAME & BIRTHDATE _____

SUBSCRIBER'S SOCIAL SECURITY # _____

IF PATIENT IS A MINOR – MOTHER'S NAME_____

FATHER'S NAME _____

MOTHER'S OR FATHER'S EMPLOYER _____

I HEREBY AUTHORIZE RELEASE OF PERTINANT INFORMATION TO MEDICARE AND TO MY INSURANCE COMPANY OR THEIR PHYSICIAN.

SIGNATURE _____**DATE**_____

PATIENTS OCULAR & MEDICAL HISTORY FORM

Name:	**Date:**
Age:	**Medical Doctor:**
Diabetic? Yes No # of years:	**Previous Eye Doctor:**
Referred by:	**Last Eye Exam:**
☐**TV** ☐**Friend** ☐**Brochure** ☐**Internet** ☐**Mailing**	**e-mail address:**

☐ **Reason for this visit:** ☐Yearly exam to have glasses/contacts checked ☐ Vision has changed
☐ Diabetic Evaluation ☐ Cataract Evaluation ☐Second Opinion ☐LASIK Evaluation

☐ **Any eye symptoms you have had:**

☐ Blurred Vision	☐ Burning	☐ Eye Fatigue
☐ Dryness	☐ Stinging	☐ Light Sensitivity
☐ Cataracts	☐ Itching	☐ Headaches
☐ Spots / floaters / flashes	☐ Tearing	☐ Migraines
☐ Reading Difficulty	☐ Redness	☐ Diabetes
☐ Glare / Halos	☐ Tired Eyes	☐ Poor Night Vision
	☐ Pressure	☐ OTHER

LIST MEDICATIONS/PILLS:

DRUG ALLERGIES: ☐ No ☐Yes Please List

Past, Medical, Family and Ocular History

Medical History & System Review			Ocular History		
Self		*Family*	*Self*		*Family*
☐	High blood pressure	☐	☐	Cataracts	☐
☐	Heart Condition:	☐	☐	Glaucoma	☐
☐	Diabetes _____ years	☐	☐	Macular Degeneration	☐
☐	Cancer:	☐	☐	Dry Eyes	☐
☐	Arthritis	☐	☐	Amblyopia/Lazy Eye	☐
☐	Respiratory Disease:	☐	☐	Retinal Disorders	☐
☐	Ear / Nose / Throat Problems:	☐	☐	Infections	☐
☐	Circulation Problems:	☐	☐	Eye Surgery	☐
☐	Neurological Problems:	☐	☐	Laser Treatment	☐
☐	Allergies:		☐	Other:	
☐	Other:				

Social History: Please indicate your use of the following:
Alcohol_____# of drinks per week Smoking_____# cigarettes per day____years
Do you drive? ☐ Yes ☐ No Hobbies & Special interests:

What type of eyeglass lenses do you currently wear? ☐ Single Vision ☐ Bifocal ☐Progressive
Are you satisfied with your current glasses? ☐ Yes ☐ No if no, Explain:

What type of contact lenses do you wear? ☐ soft ☐ disposable ☐ gas perm. ☐NONE

How many hours per day do you use a computer? ☐ 1-3 hrs ☐ 3-6 hrs ☐ 6+ hours

Questions:_____

UPDATED: _____ _____ _____ _____ _____ MD Signature_____

_____ _____ _____ _____ _____ _____

Our mission is to provide outstanding care in a pleasant and efficient setting. We respect your time and appreciate the privilege and trust of participating in your health care. In order to ensure that patients will be seen in a timely fashion, and that our physicians' time is respected as well, we have the following office policies:

There is a no-show fee. If an appointment is made and I do not show or call more than 24 hours in advance to cancel/reschedule, then I will be charged **$25**.

Name **Date**

I hereby assign insurance payment to be made to Dr. Ilan Cohen, for services rendered.

a. If my insurance plan requires that I obtain a **referral** from my Primary Care Doctor (internist, family practitioner or pediatrician), then **it is my responsibility** to obtain this referral.
b. I understand that I am responsible for co-payments, unmet deductibles, co-insurance fees, bounced check fees and no-show fees.
c. If, for any reason, my insurance plan does not pay for services rendered by Dr. Ilan Cohen, Dr. Nancy Argano, & Dr. Nathalie Chen or for any part of the services rendered, then it is my responsibility to pay for any and all medically necessary non-covered services.
d. If I default on the above responsibilities, I understand that I will be held responsible for any and all costs associated with collecting my debt, including court costs, collection fees which may be based on a percentage at a maximum of 33% of the debt, and a **$200** administrative fee if a court action is commenced.

I have read and understand the above policies.

Name **Date**

HIPPA Acknowledgement

I have received a copy of Cohen Eye Institute's Notice of Privacy Practices.

Signed: _____ **Date:** _____

Non-covered services

It is my understanding that my insurance plan **may not** pay for certain services provided by Eye Physicians of Central Jersey. I have been informed of this by Dr. Ilan Cohen, Dr. Nancy Argano, & Dr. Nathalie Chen and agree to pay for these uncovered services as follows:

Refraction (measurement for glasses and eyeglass prescription):	**$48**
Contact Lens Fitting	**$175 and up**
Contact Lens Evaluation	**$75 and up**

Signed: _____ **Date:** _____