

**PATIENT INFORMATION**  
**Information Change**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First M.I.  
Patient address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
How Long \_\_\_\_\_ Patient Phone # \_\_\_\_\_ Business # \_\_\_\_\_

Marital Status S \_\_\_\_\_ M \_\_\_\_\_ D \_\_\_\_\_ W \_\_\_\_\_ Sex \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
If Patient is minor, name of parent or guardian \_\_\_\_\_  
Address of responsible party if different from patient \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_

I hereby authorize the physicians of the Ocean Eye Institute to treat my minor child  
\_\_\_\_\_ (Parent / Guardian signature)

Name and # of person to contact in case of emergency \_\_\_\_\_ Phone # \_\_\_\_\_

Patient's employer \_\_\_\_\_ Student: Fulltime \_\_\_\_\_ Partime \_\_\_\_\_  
Address \_\_\_\_\_ (If minor, please list employer of responsible party)  
Driver's license# \_\_\_\_\_ State issued \_\_\_\_\_  
(If minor, please list driver's license # of responsible Party)

**INSURANCE INFORMATION**

Primary Insurance CO. \_\_\_\_\_ ID# \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Group # \_\_\_\_\_  
Subscriber address \_\_\_\_\_ Phone # \_\_\_\_\_  
Employer \_\_\_\_\_

Secondary Insurance CO. \_\_\_\_\_ ID# \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Group # \_\_\_\_\_  
Subscriber address \_\_\_\_\_ Phone # \_\_\_\_\_  
Employer \_\_\_\_\_

Other Insurance CO. \_\_\_\_\_ ID# \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Group # \_\_\_\_\_  
Subscriber address \_\_\_\_\_ Phone # \_\_\_\_\_  
Employer \_\_\_\_\_

**MEDICAL HISTORY**

Present eye complaint \_\_\_\_\_  
Family eye history (circle) Glaucoma Cataracts Diabetes Other \_\_\_\_\_  
Do you wear contact lenses? \_\_\_\_\_ Are you interested in wearing contacts? \_\_\_\_\_  
Family Physician \_\_\_\_\_  
First Last Address Phone#  
Referred by \_\_\_\_\_

I request that payment of authorized Medicare and/or other insurance benefits be made to me or on my behalf to the Ocean Eye Institute for services rendered by them to me. I authorize the release of medical information to my insurance

company so that benefits can be paid to the doctors. A copy of this signature is as good as original. I understand that I am responsible for any and all charges not covered by my insurance company.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

-----**Information Update**-----

Date \_\_\_\_\_ Patients signature \_\_\_\_\_

Date \_\_\_\_\_ Patients signature \_\_\_\_\_

Revised 03-07-02

## MEDICAL HISTORY REVIEW

Date \_\_\_\_\_

Name \_\_\_\_\_

Date of last eye exam \_\_\_\_\_ with complete medical history.

What medications do you currently take? \_\_\_\_\_

Do you have any allergies to medications? YES NO

If yes, list the medications \_\_\_\_\_

Have you had any major illness or injuries since your last visit? \_\_\_\_\_

Have you had any surgeries? \_\_\_\_\_

Do you currently have any problems in the following areas? If "YES", please provide information.

|                          | Yes | No | Explanation of Problem |
|--------------------------|-----|----|------------------------|
| EYES                     |     |    |                        |
| GENERAL                  |     |    |                        |
| EARS, NOSE, THROAT       |     |    |                        |
| CARDIOVASCULAR           |     |    |                        |
| RESPIRATORY              |     |    |                        |
| GASTROINTESTINAL         |     |    |                        |
| GENITAL, KIDNEY, BLADDER |     |    |                        |
| MUSCLES, BONES, JOINTS   |     |    |                        |
| SKIN                     |     |    |                        |
| NEUROLOGICAL             |     |    |                        |
| PSYCHIATRIC              |     |    |                        |
| ENDOCRINE                |     |    |                        |
| BLOOD, LYMPH             |     |    |                        |
| ALLERGIC, IMMUNOLOGIC    |     |    |                        |

**FAMILY:** Any changes to family medical status? YES NO If "YES", describe \_\_\_\_\_

**SOCIAL:** Changes in employment? \_\_\_\_\_ Marital Status? \_\_\_\_\_

Living arrangements? \_\_\_\_\_ Do you drive? YES NO

Do you have visual difficulty when driving? YES NO

Do you have problems with night driving? YES NO

Do you drink alcohol? YES NO

If YES: Occasional 1/day 2-3/day 4+/day

Do you smoke? Occasional 1/2 pack/day 1 pack/day 1+ pack/day

Physician's Signature: \_\_\_\_\_

Ocean Eye Institute  
601 Rt. 37 West  
Toms River, NJ 08755  
732-244-4400  
Fax. 732-505-2171  
www.oceaneyeinstitute.com

## Ocean Eye Institutes Notice of Privacy Practices

I acknowledge that Ocean Eye Institute has provided me with a copy of their Privacy Notice.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize Ocean Eye Institute to release medical and/or financial information to the following person:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Account # \_\_\_\_\_

Toms River

Forked River

Whiting

Silverton