Paul Phillips Eye and Surgery Center

6 B Minneakoning Road	64 Walmart Plaza	1 Monroe Street
Flemington, NJ 08822	Clinton, NJ 08809	Bridgewater, NJ 08807
(908) 824-7144	(908) 735-4100	(908) 526-4588

Patient Information

Name: _____ Home Phone: _____ Cell phone: _____
Last First Middle

Street Address: _____ Apt #: _____City: _____ State: _____ Zip: _____

Sex: M ◇ F ◇ Age: _____ Birthdate: ____/_____/_____ Marital status: _____ E-mail:_____

I would like to be referred to as (ex: Mrs. Smith, John, or your nickname) _____ Language: _____ SSN #: _____

Emergency Contact: _____ Emergency Contact phone: _____ Relationship: _____
Last First

Primary Care Provider (**PCP**): _____ PCP Phone: _____ PCP Fax: _____

Referring Provider: _____ Referring Provider Phone: _____

Pharmacy: _____ Pharmacy address: _____
Street City, State, Zip

Ethnicity (please circle): Decline to answer; Hispanic or Latino; Not Hispanic or Latino; Unknown/Not Reported

Race (please circle): American Indian or Alaska Native; Asian; Black or African American; Decline to Answer; Multiracial; Native Hawaiian or Other Pacific Islander; Other Race; Unknown; White

How would you like to be reminded of your appointments? Phone call ◇ Text ◇ E-mail ◇

Health Insurance Information

Please include any letters with ID #. Your insurance card is required at **each visit**. If your insurance requires an insurance referral, please obtain a referral **before** your appointment.

Primary Insurance:

Name of Insurance Company: _____ Policy #: _____ Group #: _____

Address of Insurance Company: _____ Specialist Copay: $_____
Street City, State, Zip

Name of Subscriber: _____ DOB: _____/_____/_____ Phone: _____
Last First

Address of Subscriber: _____ Relationship to patient: _____
Street City, State, Zip

Secondary Insurance (if applicable):

Name of Insurance Company: _____ Policy #: _____ Group #: _____

Address of Insurance Company: _____ Specialist Copay: $_____
Street City, State, Zip

Name of Subscriber: _____ DOB____/_____/_____ Phone: _____
Last First

Address of Subscriber: _____ Relationship to patient: _____
Street City, State, Zip

Over

How did you hear about Paul Philips Eye? _____

When was your last eye examination? _____

Do you presently wear glasses? Yes ◇ No ◇ Bifocals? Yes ◇ No ◇ No line Bifocals? Yes ◇ No ◇

If so, please bring your glasses to your appointment.

Do you or have you ever worn contact lenses? Yes ◇ No ◇

If so, please bring your contact lens information to your appointment.

Have you ever been diagnosed with an eye disease? Yes ◇ No ◇

If so, what is your diagnosis? _____

Have you ever had eye surgery? Yes ◇ No ◇

If so, what was the nature of the surgery? _____

Do you presently take any eye medication? Yes ◇ No ◇

If so, please list: _____

Please list all past surgeries and hospitalizations with the approximate date:

Procedure/Hospitalization	Approximate Date	Complications

Please list any medications you take, other than eye drops (please include over the counter, supplements, herbs):

Medication Name	Dosage	Reason

Do you have any allergies to medications or other substances (pets, food, etc.)? Yes ◇ No ◇

Allergy	Reaction

Past History

Do you or any blood relatives have/had any of the following? :

Glaucoma ◇ Cataracts ◇ Macular Degeneration ◇ Diabetes ◇

High blood pressure ◇ Thyroid/ Graves' disease ◇

I authorize the release of any medical information necessary to process all insurance claims. I authorize the release of payment for medical benefits to Paul Phillips Eye & Surgery Center. A Notice of Privacy (Right of Patients) is available for all patients upon request.

_____ _____

Signature Date

Paul Phillips Eye and Surgery Center

6 B Minneakoning Road
Flemington, NJ 08822
(908) 824-7144

64 Walmart Plaza
Clinton, NJ 08809
(908) 735-4100

1 Monroe Street
Bridgewater, NJ 08807
(908) 526-4588

Medical Information Release Form
(HIPAA Release Form)

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

◇ I authorize the release of information including the diagnosis, records, examinations rendered to me and claims information. This information may be released to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

◇ I do not authorize the release of this information to anyone.

The release of information will remain in effect until terminated by me in writing.

Messages

Please call: ◇ my home _____ ◇ my work _____ ◇ my cell_____

If unable to reach me:

◇ You may leave a detailed message

◇ Leave a message asking me to return your call

◇ _____

Unified Chart

I understand that information contained in my NextGen chart may be shared electronically with other providers and affiliates that are involved in my care at Hunterdon Healthcare. I also understand that information contained in my NextGen chart may be available electronically to the Hunterdon Medical Center Emergency Department in the event of an emergency.

Signature: _____ **Print Name**: _____ **Date**: _____
Patient or guardian