

MERCER EYE ASSOCIATES, PA
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Diseases and Surgery of the Eye

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Corneal and External Disease

Welcome and thank you for choosing Mercer Eye Associates for your eye care health. Regular eye exams are important to your lifetime vision. Our mission is to provide you with the highest quality of care for you and your family. Your eye health and vision is our top priority. Our team is dedicated to providing you with the personalized care you deserve using the latest, most innovative techniques in eye care.

New patient visits may take up to 1 ½ to 2 ½ hours. Your eyes will be dilated as part of your exam. You may want to bring a driver if you have difficulty with dilation. Bright light can be uncomfortable for a period of time following dilation, therefore we recommend bringing sunglasses for your comfort. If you do not have sunglasses, a disposable pair will be provided. It is recommended that patients having a cataract evaluation bring a family member or other person who will assist in your care after surgery with them for the appointment.

INSTRUCTIONS FOR NEW PATIENTS

Please bring with you:

- Insurance ID card/s and a photo ID. These items will be scanned into our electronic medical record [EMR] for future use.
- All information regarding your medical and surgical history.
- A list of all current medications. Include eye drops, vitamins and any over-the-counter, Nonprescription medications you take regularly on your list.
- Your glasses, those used for reading and distance. If you are a contact lens wearer, please bring your current contact lens prescription.
- Any correspondence from your referring doctor related to your eye exam, as well as his/her name and address.

Your appointment with Dr. _____ is _____ at _____.

PLEASE NOTE: IF YOU UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT, PLEASE NOTIFY THE OFFICE 24 HOURS IN ADVANCE SO THAT OTHERS MAY USE THE APPOINTMENT TIME. THE PRACTICE RESERVES THE RIGHT TO CHARGE A \$50.00 CANCELLATION FEE IF NOT NOTIFIED IN ADVANCE.

IMPORTANT NOTES:

- Children under the age of 18 must have a parent or legal guardian present for the initial visit.
- If you are diabetic, you may want to bring a snack due to the length of a new patient visit.
- If you are being seen for cataract evaluation and wear contacts, you must not wear your contacts for two weeks prior to your scheduled appointment.
- If you do not speak English, you will need to bring someone who can translate for you.
- If you need assistance getting in or out of the exam chair or in using the rest room, you must bring someone who can assist you.

INSURANCE INFORMATION:

As a courtesy to our patients we make great efforts to participate in most insurance programs. It is important that you be aware of your insurance benefits and how they apply to your eye care. Please ask when making your appointment if we participate with your insurance or contact your insurance carrier for verification. Unfortunately, we DO NOT participate with vision plans at this time. We are participating providers with Medicare. We will accept what Medicare APPROVES. Typically after your annual deductible has been met, Medicare will pay 80% of the approved amount. The patient or the secondary insurance pays the remaining 20%.

Referrals: It is the patient's responsibility to know if a referral is needed and to acquire one before your scheduled appointment. You may refer to your benefits department or call the member services number on your insurance card for referral requirements. Cataract evaluation patients will need referrals for a minimum of 5 visits.

Payments: All co-payments and refraction fees* are due at the time of service. We accept cash, checks, Visa, MasterCard, Discover, American Express, bank debit cards and flexible spending account cards.

***Refraction fees** are not covered by Medicare or most other insurances. That is the part of the eye exam by which we determine whether you can be helped in any way by a new glasses prescription. It is how we determine the best possible visual acuity [vision] and function of your eye, which is essential medical information to assess your eyes and identify problems. Refraction fee \$40.00.

Today's Date: _____ **MERCER EYE ASSOCIATES - Patient Information**

Name: _____ DOB _____ () Male () Female

Address: _____ City: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____ Marital Status: _____

SS #: ___ - ___ - ___ - ___ - ___ Emergency Contact [not living with you] Name: _____
[last 4 #'S required - full SS# required for computer access to PHI]

Phone: _____

Are you the subscriber to your insurance?

Yes No, List Subscriber's Name/Relationship: _____ DOB: _____

Primary Insurance Carrier Name: _____ ID #: _____

Secondary Insurance Carrier Name: _____ ID #: _____

I authorize Mercer Eye Associates to release any medical information regarding my eye exam, treatment and history to my referring physician for continuity of care and to my insurance carrier for billing purposes.

Signature/Date _____

Note: You can now access your personal health information [PHI], a summary of your office visit, via your personal computer or smart phone by visiting our secure web site at www.myeyerecords.com .

Thank you. *Physicians and Staff of Mercer Eye Associates.*

Email address _____

Racial background: () DECLINE

() Black or African American () Caucasian () More than one race

() American Indian/Alaska Native () Asian () Other

Ethnicity and Race Identification

() DECLINE () Hispanic or Latino () Not Hispanic or Latino () Unknown

NOTE: Please use the back of this form if additional space needed.

Known Allergies: _____

Current Medications [include vitamins & over the counter meds]: Have a list? Please give receptionist to copy.

Local Pharmacy Name/Address: _____ Phone: _____

Mail Order Pharmacy Information: _____

Referred by: Physician _____ Friend or Family _____

Primary Care Physician Name: _____ City: _____ Phone: _____

Cardiologist Name: _____ City: _____ Phone: _____

Endocrinologist Name: _____ City: _____ Phone: _____

**MERCER EYE ASSOCIATES
MEDICAL HISTORY & REVIEW OF SYSTEMS**

Today's Date: _____ Name: _____ DOB _____

Tobacco Use: YES NO NEVER if yes, How much? _____/day If Yes, How Long? Date Quit? _____yr.

Alcohol Use: YES NO Social How much per day? _____ Week? _____

PAST SURGICAL HISTORY: (please include dates)

REVIEW OF SYSTEMS- Please check each item "YES or NO" as it relates to your health.

<p>EYES:</p> <p>Previous Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Contact Lens <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Double Vision <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Macular Degeneration <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dry Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Flashes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Floater <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>RESPIRATORY:</p> <p>Cough <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Congestion <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>GASTROINTESTINAL</p> <p>Heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Nausea/Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Jaundice/Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>BLOOD/LYMPHATICS</p> <p>Easy Bruising <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Gums Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prolonged Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heavy use of Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>MUSCULOSKELTAL</p> <p>Stiffness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Swelling <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>EAR, NOSE, THROAT</p> <p>Hard of Hearing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ringing in Ears <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Vertigo <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>GENITO-URINARY</p> <p>Pain/Difficulty Urinating <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood in Urine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>History of Kidney Stones <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>History of STD's <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>SKIN</p> <p>Rash/Sores <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Lesion <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hives <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Eczema <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>CARDIOVASCULAR</p> <p>Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting Spells <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Irregular Heart Beat <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty Lying Flat <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>PSYCHIATRIC</p> <p>Anxiety/Depression <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mood Swings <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty Sleeping <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>NEUROLOGICAL</p> <p>Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Weakness/Paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Numbness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tremors <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>CONSTITUTIONAL</p> <p>Fatigue/Weakness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Weight Gain/Loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>ENDOCRINE</p> <p>Increased Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Increased Hunger <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Increased Urination <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Increased Sweating <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fingernail Changes <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>IMMUNOLOGIC</p> <p>Hives <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Itching <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Runny Nose <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sinus Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Please provide additional information for "YES" answers as needed. [You may use the back of this form.]
