MERCER EYE ASSOCIATES, PA
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Lawrenceville, NJ 08648

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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 _____

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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 _____

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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

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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 <u>your</u> health.

EYES:

Previous Surgery	□ Yes □ No
Contact Lens	□ Yes □ No
Pain	□ Yes □ No
Double Vision	□ Yes □ No
Glaucoma	□ Yes □ No
Cataracts	□ Yes □ No
Macular Degeneration	□ Yes □ No
Dry Eyes	□ Yes □ No
Flashes	□ Yes □ No
Floaters	□ Yes □ No

RESPIRATORY:

Cough	□ Yes □ No
Congestion	□ Yes □ No
Wheezing	□ Yes □ No
Asthma	□ Yes □ No

BLOOD/LYMPHATICS

Easy Bruising	□ Yes □ No
Gums Bleeding	□ Yes □ No
Prolonged Bleeding	□ Yes □ No
Heavy use of Aspirin	□ Yes □ No

GASTROINTESTINAL

Heartburn	□ Yes □ No
Nausea/Vomiting	□ Yes □ No
Jaundice/Hepatitis	□ Yes □ No

MUSCULOSKELTAL

Stiffness	□ Yes □ No
Arthritis	□ Yes □ No
Joint pain	□ Yes □ No
Joint Swelling	□ Yes □ No

EAR, NOSE, THROAT

Hard of Hearing	□ Yes □ No
Ringing in Ears	□ Yes □ No
Vertigo	□ Yes □ No

GENITO-URINARY

Pain/Difficulty Urinating	□ Yes □ No
Blood in Urine	□ Yes □ No
History of Kidney Stones	□ Yes □ No
History of STD's	□ Yes □ No

SKIN

Rash/Sores	□ Yes □ No
Lesion	□ Yes □ No
Hives	□ Yes □ No
Eczema	□ Yes □ No

CARDIOVASCULAR

Chest Pain	□ Yes □ No
Dizziness	□ Yes □ No
Fainting Spells	□ Yes □ No
Shortness of Breath	□ Yes □ No
Irregular Heart Beat	□ Yes □ No
Difficulty Lying Flat	□ Yes □ No

PSYCHIATRIC

Anxiety/Depression	□ Yes □ No
Mood Swings	□ Yes □ No
Difficulty Sleeping	□ Yes □ No

NEUROLOGICAL

Seizures	□ Yes □ No
Weakness/Paralysis	□ Yes □ No
Numbness	□ Yes □ No
Tremors	□ Yes □ No

CONSTITUTIONAL

Fatigue/Weakness	□ Yes □ No
Fever	□ Yes □ No
Weight Gain/Loss	□ Yes □ No

ENDOCRINE

Increased Thirst	□ Yes □ No
Increased Hunger	□ Yes □ No
Increased Urination	□ Yes □ No
Increased Sweating	□ Yes □ No
Fingernail Changes	□ Yes □ No

IMMUNOLOGIC

Hives	□ Yes □ No
Itching	□ Yes □ No
Runny Nose	□ Yes □ No
Sinus Pressure	□ Yes □ No

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

_____

_____