PATIENT INFORMATION - PLEASE COMPLETE ALL INFORMATION

Please Print *(THANK YOU!)*

LAST NAME | FIRST NAME | MIDDLE INITIAL | ❑ DR. ❑ MISS ❑ MS. ❑ MRS. ❑ MR.

ADDRESS | CITY | STATE | ZIP

PHONE HOME | CELL WORK | SOCIAL SECURITY

DATE OF BIRTH | AGE | SEX | RACE | MARITAL STATUS | EMAIL ADDRESS

OCCUPATION | EMPLOYER NAME

EMPLOYER PHONE | EMPLOYER ADDRESS | CITY | STATE | ZIP

SPOUSE/PARENT/GUARDIAN | SOCIAL SECURITY | OCCUPATION

PERSON TO CONTACT IN CASE OF EMERGENCY

PERSON'S RELATION TO YOU | HOME PHONE | WORK PHONE | ZIP

EMPLOYER PHONE | EMPLOYER ADDRESS | CITY | STATE | ZIP

WHO REFERRED YOU TO OUR OFFICE? ❑ EYE DR. ❑ FAMILY DR. ❑ INSURANCE CO. ❑ FRIEND ❑ OTHER

NAME OF REFERRER | TELEPHONE #

ADDRESS | CITY | STATE | ZIP

PERSONAL PHYSICIAN | TELEPHONE

ADDRESS | CITY | STATE | ZIP

INSURANCE INFORMATION

PRIMARY	**SECONDARY**
AGREEMENT/I.D. #	**AGREEMENT/I.D. #**
GROUP #	**GROUP #**
SUBSCRIBER NAME	**SUBSCRIBER NAME**

WORKMAN'S COMPENSATION ❑ **CARRIER** | **AUTO ACCIDENT** ❑

CLAIM # | **CLAIM #**

LEGAL ❑ **ATTORNEY NAME** | **ADDRESS** | **PHONE #**

RELEASE AND ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE NEVYAS EYE ASSOCIATES TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME. I ALSO AUTHORIZE AND REQUEST MY COMPANY TO PAY DIRECTLY TO NEVYAS EYE ASSOCIATES THE AMOUNTS IN MY PENDING CLAIM FOR ALL SERVICES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES NOT PAID BY MY INSURANCE COMPANY.

SIGNATURE _____ **DATE** _____

PATIENT'S PERSONAL HISTORY - PLEASE COMPLETE ALL INFORMATION

Please Print

(THANK YOU!)

Last Name _____ First Name _____ Middle Initial _____ Title _____ Date _____

What are your visual problems & symptoms? _____ **How long?** _____

Please answer the following questions about your medical status and history.

1. Do you have any drug or food allergies? What are you allergic to? _____

   ❑ Yes ❑ No If yes, list symptoms: _____

2. Are you allergic to latex? ❑ Yes ❑ No If yes, list symptoms: _____

   _____

3. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, heart disease, stroke, asthma, cholesterol, thyroid problems, cancer or been hospitalized?

   ❑ Yes ❑ No If yes, please explain: _____

   ****If diabetic, which year were you diagnosed?** _____

4. Have you ever had asthma, emphysema, or been treated for any breathing difficulties? ❑ Yes ❑ No

5. Have you ever been treated for any eye disease/ had eye surgery/ been struck or hit in the eye/ had a black eye?

   ❑ Yes ❑ No If yes, please provide date and details: _____

   _____

6. Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cataract, glaucoma, macular degeneration)?

   ❑ Yes ❑ No If yes, please specify family members with these conditions: _____

   _____

Family and Social History

Do you:	Yes	No	Do you:	Yes	No
Wear glasses*			Use eye drops (prescription & over the counter?) List:		
Wear contacts* ❑ Soft ❑ Hard					
Do you smoke? If yes, how much? ___ (packs) How Long? ___ (years)					
Do you drink alcohol? If yes, how much? ___			Do you work? If yes, how many hours per week? What kind of work do you do? List:		
How much do you weigh? Height?					
Do you have Difficulty:			**Do you have Difficulty:**		
Driving? ❑ With Glasses ❑ Without Glasses			Seeing at night?		
With headlights? ❑ With Glasses ❑ Without Glasses			In bright light?		
Seeing road signs? ❑ With Glasses ❑ Without Glasses			Crossing the street?		
Reading? ❑ With Glasses ❑ Without Glasses			Recognizing the faces of people across the street?		

* Who wrote your prescription for the glasses/contacts you are wearing? _____

* When was your last visit to the optometrist? _____

PLEASE TURN PAGE OVER TO CONTINUE ▶

Review of Systems

Do you currently have any of the following problems:	Yes	No	If Yes, please explain
Chronic fever, fatigue, unexpected weight gain/loss	❑	❑	
Ear/nose/throat problems (e.g. hearing loss, sinus infection, sore throat)	❑	❑	
Heart problems (e.g. chest pain, irregular heart beat, high blood pressure)	❑	❑	
Respiratory problems (e.g. shortness of breath, wheezing, coughing, asthma)	❑	❑	
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	❑	❑	
Urinary problems (e.g. pain or discomfort, blood in urine), difficulty voiding	❑	❑	
Skin problems (e.g. rashes, excessive dryness)	❑	❑	
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	❑	❑	
Neurological problems (e.g. numbness, weakness, headache)	❑	❑	
Psychiatric problems (e.g. depression, anxiety)	❑	❑	
Endocrine problems (e.g. diabetes, thyroid disease)	❑	❑	
Blood problems (e.g. anemia, bleeding tendency)	❑	❑	
Have you ever been exposed to Hepatitis B?	❑	❑	
Have you ever been exposed to Hepatitis C?	❑	❑	
Have you ever tested positive for the HIV Virus?	❑	❑	

Do you drive? ❑ Yes ❑ No

Please list your prescription and over-the-counter medication, including vitamins and daily aspirin _____

_____

_____

_____

_____

- THANK YOU -

Please use space below if needed for further explanations.

_____ _____

Registration :

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Address	Home: / Work: / Cell:	How did you hear of us?
Address 2	Email:	

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Pharmacy Phone

Provider **Family Physician** **Referring Physician**

Medical Insurance	Name & Address	Policyholder	Relationship	Copay	Policy ID	Group ID
1						
2						
3						

Guarantor (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

HIPAA Approved Contacts

1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

2. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Nevyas Eye Associates PA , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date	
X		Phone: / Email:

Please attach all pertinent insurance ID cards for photocopying.

Nevyas Eye Associates

COVID – 19 Patient screening

1. Have you been tested for COVID – 19? If so, when? ☐ Yes ☐ No
   _____
2. Have you traveled in the past 14 days? If so, where? ☐ Yes ☐ No
   _____
3. Have you had contact with a person who has been diagnosed with the Coronavirus disease? ☐ Yes ☐ No
4. What will your mode of transportation be to get to our office? _____
5. Are you ambulatory without the assistance of anyone? ☐ Yes ☐ No
6. Do you have a fever? ☐ Yes ☐ No
7. Do you have a recent onset cough? ☐ Yes ☐ No
8. Do you have shortness of breath? ☐ Yes ☐ No
9. Do you have other acute respiratory symptoms? ☐ Yes ☐ No
10. Anyone accompanying you will need to remain outside of our office. Will this present a problem? ☐ Yes ☐ No

If any of these conditions change prior to your appointment date, please call to cancel your appointment.

You will need to bring a clean mask with you that you are required to wear for the duration of your stay in our office.

Patient name (printed) _____ DOB_____

Patient Signature _____ Date_____

Staff Signature _____ Date _____

Office Protocol – NEA

Patient arrives at Bala:

When you arrive in the parking lot, please call 610-668-2777, tell us that you have arrived and the following will take place:

- you will be asked to pull up along our curb to have your temperature taken
- we will ask you to sign the questionnaire that you answered during your appointment confirmation
- you may be asked to park your car and wait until we call you to come in for your appointment

Patient arrives at Marlton, NJ:

When you arrive in the parking lot, please call 856-985-1084, tell us that you have arrived and the following will take place:

- you will be asked to come up to our office door to have your temperature taken
- we will ask you to sign the questionnaire that you answered during your appointment confirmation
- you may be asked to wait in your car until we call you to come in for your appointment

Patient arrives at Northeast office:

When you arrive in the parking lot, please call 215-969-6367, tell us that you have arrived and the following will take place:

- you will be asked to enter the vestibule of our office to have your temperature taken
- we will ask you to sign the questionnaire that you answered during your appointment confirmation
- you may be asked to return to your car and wait until we call you to come in for your appointment

You will be required to wear a protective mask from the time you arrive in our parking lot until you leave our office.

When you enter our offices:

There will be a dispenser of alcohol based hand sanitizer. A staff member will dispense a small amount for you. Thoroughly rub it onto your hands and allow it to dry.
You will then be greeted by a technician who will accompany you to an exam room.

When you enter our exam rooms:

PLEASE NOTE: All exam room surfaces, instruments and computers are thoroughly cleaned and disinfected after each patient has stepped out of the room, regardless of whether the devices were used or not.

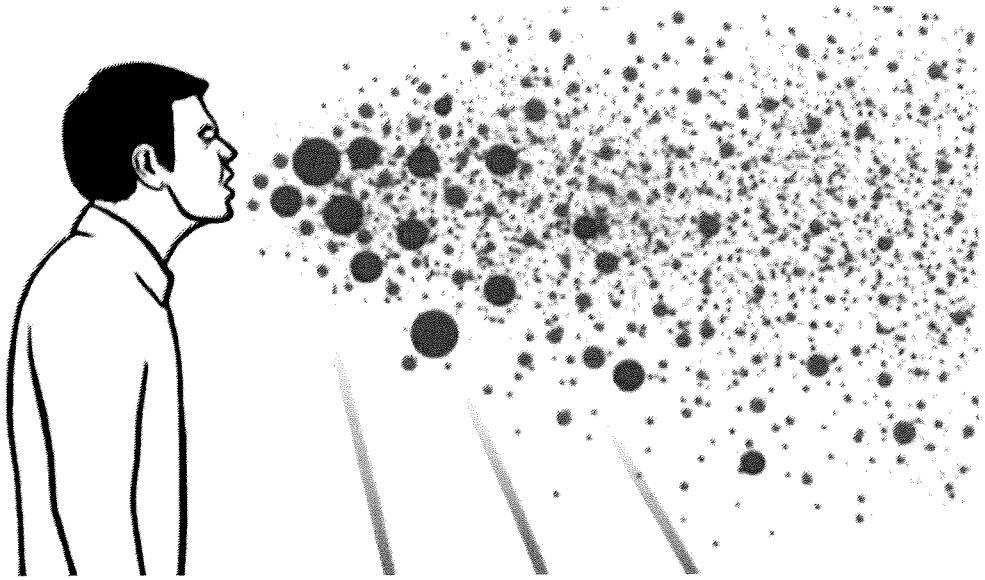
When your exam is complete:

- If you do not require a follow-up appointment, a technician will escort you to the exit.
- If you do require a follow-up appointment, a technician will call a receptionist from your exam room and an appointment will be booked. You will then be given an appointment card and be escorted to the exit.

As much as we would like to have a conversation with you and catch up on the past few months, we need to limit the amount of talking that usually occurs in our exam room. Your safety and that of our staff is extremely important to us.

By limiting conversation in the exam room, we reduce the potential for contamination.

The diagram below shows saliva droplets from talking.



Infections can be spread through contact with these droplets.

The combination of wearing a mask and limiting conversation will greatly reduce the risk of spreading any airborne virus such as COVID-19.

We appreciate your understanding and observance of this policy.

Thank you.