HADE EYE CARE
COMPREHENSIVE OPHTHALMOLOGY

1 Indian Road, Suite 9, Denville, NJ 07834
p. 973.586.2188 • f. 973.586.2218

Dear Patient:

Welcome to Hade Eye Care. Our mission is to provide you with the highest level of medial care. The doctor is an ophthalmologist who is trained in the diagnosis and treatment of diseases of the eye. If possible, all evaluation and testing will be completed on your initial visit. Patients should realize that a complete eye exam, with or without testing, could last anywhere from one hour to one and a half hours.

First-time patients must provide a thorough medical history, including all medications. Enclosed is a form to aid in obtaining your medical history. Also attached you will find our patient demographic sheet, financial policy, and HIPAA Notice of Privacy Practice. All the information enclosed is important for your understanding of the services provided and financial responsibility and are yours to take for later reference.

At your visit, a vision test and measurement of intraocular pressure will be performed, and either dilation of your pupils using eyedrops or a broad view picture (Optos fundus) of the back of your eye will be done. If dilation is done, it may take approximately 15 minutes, and then the physician will complete the examination. Depending on the physician's findings, additional testing may be performed. Full eye exams, for either medical or routine reasons, usually require a refraction. Some insurance companies DO NOT cover this, which may require an additional fee.

As an alternative to dilation, our office offers Optos wide field fundus imaging which will allow the necessary examination of your eye without the use of dilating eye drops, for an additional fee.

If you wear contact lenses and need a renewal on your prescription, you will need to have a contact lens evaluation. This is not covered by insurance companies and will require an additional fee.

What you need to bring:

- Your insurance cards
- Referral from your primary care provider, if required
- Eyeglasses
- Contact lenses with packaging or contact lens prescription
- List of current medications
- List of allergies
- Optional: Past medical records and diagnostic testing from prior eye doctors

If your visit is for routine eye care examination of eyes, vision, or contact lenses, please be aware that insurance plans may only cover some or all of these benefits. **Please check with your insurance company to see if these benefits are covered under your plan.**

Sincerely,
The Office of Hade Eye Care, LLC

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INFORMATION REGARDING DILATION vs OPTOS FUNDUS EYE EXAM

It may be important to examine the back of your eyes today for evaluation of the retina, optic nerve, and adjacent structures. This may reveal the presence of a serious systemic condition as well as other eye conditions. Dilating eye drops are used to enlarge the pupil of the eye to allow the physician to obtain a view of the inside of your eyes. The dilation eye drops generally take about 15 minutes to work.

Dilation can blur vision for a length of time, which varies from person to person. Dilation may also make bright lights bothersome. It is not possible for us to predict what degree your vision will be affected. If you are concerned about these problems, you may wish to make alternative transportation arrangements, although it may be possible to drive with the aid of sunglasses. Adverse reactions, such as acute angle closure glaucoma, may be triggered from dilating eye drops. This is extremely rare and treatable with immediate medical attention.

As an alternative to dilation, we offer the Optos Fundus examination in which a specialized camera can obtain a wide field view of the inside of your eye without the use of dilating eye drops. This technology also allows the doctor to analyze the anatomy of the inner eye and the images can be isolated, enlarged, studied and compared to previous images. Comparison is valuable in detecting and tracking disease. Be advised that the Optos camera will not be successful for all patients (examples: very small pupils, excessive blinking, pronounced cataracts, droopy eyelids, etc.), and although you may prefer to have the Optos photo taken, we may determine that dilation is necessary. **The Optos is not covered by insurance providers. If you elect this option, and it is completed, your out-of-pocket fee on the day of service is $45.** There are some conditions that warrant the Optos and can be submitted to your insurance. Examples of such conditions are diabetes and high blood pressure which have produced retinal complications, plaquenil therapy, glaucoma, macular degeneration, and other previously identified retinal disorders. Please ask if you are unsure or have any questions or concerns regarding the Optos Fundus exam.

INFORMATION REGARDING THE REFRACTION VISION TEST

We may need to perform a vision test called **refraction** to check your vision today. A refraction is a diagnostic test used to determine the patient's best ability to see and is the basis for prescribing glasses, contacts, or other optical devices. A series of lenses are presented to you to determine which lens provides you with the clearest possible vision, or vision acuity. This is an essential part of most ophthalmologic evaluations. It is necessary to perform a refraction during any exam where vision is a complaint, your annual eye exam, or for any vision change since your last visit.

SOME INSURANCE COMPANIES, INCLUDING MEDICARE, DO NOT COVER THE REFRACTION MEASUREMENT.
We will submit for this service (if you have insurance other than solely Medicare which we know does not cover refraction). If it is not paid by your insurance as a covered service, you will be billed accordingly. Our office fee for refraction is $50. This fee is collected in addition to any co-payments, co-insurance, or deductible payments.

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FINANCIAL POLICY

If you have no insurance or are a member of insurance plans that we do not participate in, FULL PAYMENT OF SERVICES IS DUE AT THE TIME THEY ARE RENDERED. We accept cash, personal checks and credit cards.

- **HMO and Managed Care Plans:** Co-payment is due at the time of appointment. If a referral is required from your primary care physician, you are responsible for obtaining it prior to your appointments; in the absence of a referral, you will need to reschedule your visit.
- **Medicare:** You are responsible for your annual deductible and 20% co-insurance payment. In addition, you are generally responsible for durable equipment and non-covered services. Please note that refraction is a non-covered service according to Medicare regulations. For any questions about the non-covered refraction, please call Medicare.
- **Workers' Compensation:** You are responsible for submitting bills to your insurance company. You are responsible for any bills not paid in full within thirty (30) days.
- **Motor Vehicle Accidents:** We are not responsible for submitting bills to your insurance company. You are responsible for any deductibles or co-payments and will be fully responsible for any bills not paid in full within thirty (30) days. We will gladly provide you with a receipt that you can submit for reimbursement.
- **Hospitalization:** Physician fees for hospital visits, including surgery, will be billed directly to your insurance company. You are responsible for any non-covered fees. Our fees do not include charges for the hospital or hospital dispensed medications, or another physician's fees.
- **Responsible Parent:** In case of divorced or separated parents, our policy is that the parent bringing the child into our office is responsible for the full payment of out-of-pocket fees at the time of service.
- **Contact Lenses:** Payment or credit card information is required at the time an order is placed.
- **Returned Checks:** Any check payments that do not clear the bank will be subject to a $45.00 returned check fee.

We will gladly discuss your proposed treatment and answer any questions related to our fees. We will also be happy to discuss general questions concerning insurance. However, please understand that **we cannot be familiar with the specific terms of every insurance policy issued. That is between you and the insurance company with whom you have contracted.** Therefore, for specific answers to questions, you should call your insurance company directly.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

With my consent, Hade Eye Care may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Hade Eye Care Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have reviewed the Notice of Privacy Practices prior to signing this consent. Hade Eye Care reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Hade Eye Care, 1 Indian Road, Suite 9, Denville, NJ 07834.

With my consent, Hade Eye Care may call, e-mail, or mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and to receive free health resources and periodic special offers from our office. Hade Eye Care may also leave messages on my voicemail.

I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Hade Eye Care may decline to provide treatment to me.

ASSIGNMENT OF BENEFITS:
I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to my provider at Hade Eye Care for any services furnished by them. I authorize any holder of medical information about me to release to my Insurance Company, its agents, or any other carrier that I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.

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CONTACT LENS EVALUATION

The contact lens evaluation applies to anyone either wearing or wanting to wear contact lenses. This evaluation involves checking vision with current lenses, and possibly presenting a series of alternate lenses to determine which prescription provides the sharpest and clearest vision. It also involves an evaluation of the fit and centration of the lenses by the physician using the microscope. This testing is needed to ensure that the lenses are not adversely affecting your eyes.

At your examination you will be instructed on insertion and removal of the contact lenses (if needed) and give you instruction on contact lens care regimens. After receiving these instructions, you will wear the lenses for a trial period of one to two weeks. If you have a problem and elect to forgo the follow-up care and return beyond the initial 60 days period, you will be responsible for a contact lens refit fee.

If you are a previous wearer and no changes have been made to your contact lens prescription or contact lens brand/type, you are not required to return for contact lens related follow-up visits.

Contact lenses are medical devices that are worn on the eye and are required by law that patients return yearly to renew your contact lens prescription so that the doctor can assess the health of your eyes.

If you decide or need to change to a different category or type of lens after the initial visit, additional fees may be added.

If you present to the office as a new patient but do not have complete information regarding the type and brand of contact lenses that you are currently wearing, you will be considered as a refit and be charged accordingly.

A contact lens evaluation or fitting fee will be added to your out-of-pocket responsibility on the day of service. Except where noted, the fees include the trial lenses, contact lens-related follow-up visits for 60 days, and a contact lens solution starter kit. Any visits following the 60 days evaluation will be subject to a fitting service fee.

The evaluation fees DO NOT include the cost of the of contact lenses.

CONTACT LENS FITTING FEES WILL NOT BE REFUNDED OR CREDITED.

FEES FOR CONTACT LENS EVALUATIONS/EXAMS (Price range depends on type of lens and complexity of Rx)

Contact lens evaluations/verifications for existing wearers ..... $70 - $100
Refit of contact lenses (change of type or brand of contacts for existing contact lens wearers) ..... $130 - $200
Fitting for a new contact lens wearer ..... $225 - $350

CONTACT LENS PRESCRIPTIONS ARE VALID FOR ONE YEAR

Fairness to Contact Lens Consumer Act:
This act went into effect February 4, 2004. As stated by this Act, you are entitled to a copy of your contact lens prescription once the prescription is finalized by the examining doctor. Receiving a trial lens IS NOT a finalized prescription. A finalized prescription is determined at the follow-up appointment after you have been wearing the trial lenses.

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and related to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by !aw.

YOUR RIGHTS UNDER THE PRIVACY RULE

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices: We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on its website.

You have the right to authorize other use and disclosure: This means you have the right to authorize any use or disclosure of PHI that is not specified in this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to see your PHI. You may revoke an authorization at any time in writing, except to the extent that your healthcare provider or our practice has taken an action in reliance on the use or disclosure indication in the authorization.

You have the right to request an alternative means of confidential communication: This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., fax, telephone) and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI: This means you may inspect, and obtain a copy of, your complete health record. We have the right to charge a reasonable fee for paper or electronic copies as established by state or federal guidelines.

You have the right to request a restriction of your PHI: This means you may ask us, in writing, not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out of pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information: This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability: This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside this office.

You have the right to receive a privacy breach notice: You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact the office. Contact information is provided on the fol!owing page under Privacy Complaints.

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HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment: We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices: We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide you information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan to disclose information to the health plan sponsor. You will have the right to opt out of such special notices and each such notice will include instructions for opting out.

Payment: Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions, and patient safety activities.

Health Information Organization: The practice may elect to use a health information organization or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment or healthcare operations.

To Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures: We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities, health oversight activities, in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; workers' compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

PRIVACY COMPLAINTS

You have the right to complain to us or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying us at:

Hade Eye Care, LLC, 1 Indian Road, Suite 9, Denville, NJ 07834

We will not retaliate against you for filing a complaint.

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PATIENT PORTAL INSTRUCTIONS

We encourage you to use the Patient Portal to directly enter some of your background information into your office file prior to coming in for your appointment. This will make your time in the office more efficient.

You will get an email from "Patient Portal" with a title of "Welcome to your Hade Eye Care Patient Portal". If you do not see it, check your Spam folder. If it is still not there, call the office to notify us to resend the email. The email will provide you with instructions and a link to set up a Password. Your Username will be the email that you provided.

Once you log into the Patient Portal, at the top of the page, you will see the words "My Health". Click on it and you will then see several Options on the left-hand side of the screen (Contact Info, Insurance and Pharmacy, Medications, etc.).

Start by clicking on the "Contact Info". Follow the guide below to fill in the appropriate information:

Contact Info:

Fill in Date of Birth, Birth Sex, Preferred Contact Method, Emergency Full Name & Phone #, Patient Home Phone #, Patient Work Phone #, Patient Mobile Phone #, Preferred Phone, Street Address, City, State, Zip.
Hit "Save and Continue"

Insurance & Pharmacy: *Leave Insurance section alone.*

- Pharmacy: Click on "Add Surescript Pharmacy". In Zip code field, enter Zip code of your pharmacy, hit "Search" and select your pharmacy.
- If you also have a mail order pharmacy, after you finish the above step, type the name of the mail order pharmacy in the Name field and under Type, click the circle next to "Mail" and hit "Search" and select your mail order pharmacy.

Hit "Save and Continue"

Medications:

If you take no medications, select "Mark no Medications" at the top of the page.

- **For each medication** that you take; in the Drug Name box, type the name of your medication. Once you see your medication appear in the area below the box, click on the appropriate name and then select the dosage that you take. If you do not know the dosage, choose "Add 'Medication X' with unspecified dispensable". Repeat process for all medications that you take.

Hit "Save and Continue"

Allergies:

If you have no allergies, select "Mark No Known Allergies" at the top of the page.

- Otherwise, type the name of the medication and select the appropriate listed medication. Repeat process for more known allergies.

Hit "Save and Continue"

Past Medical and Ocular History:

- Select boxes next to the listed conditions as apply to you. If you have no medical problems, select "None". If you do not see a condition that you have, check "Other" and type in the condition(s) not listed.
- Repeat this process in the section below, Past Surgeries, and Ocular History.

Hit "Save and Continue"

Social History:

- Only answer the following: What is your smoking status? (Select from drop down menu)
  Occupation (Type in answer; if retired, list former occupation)

Hit "Save".

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CONSENTS AND SIGNATURES

OPTUS FUNDUS EXAM/DILATION AGREEMENT/CONSENT:

By signing below, I certify that I have received and understand the Optos fundus exam, the benefits, and possible fees for the service. Also, that I have received and understand the process and possible effects of dilation. Also, that I have had all my questions answered. For a yearly eye exam, or any eye conditions affecting the back part of your eye, **you must choose either dilation or the Optos fundus examination.**

☐ I want to have the Optos fundus examination. The out-of-pocket expense of $45.00 and will not be submitted to any insurance plan.

☐ I decline the Optos fundus examination and opt for dilation, and hereby authorize the physician and/or such assistants as may be designated by him to administer dilating eye drops.

Initials:_____ Date:_____

REFRACTION AGREEMENT/CONSENT:

By signing below, I certify that I have received and understand the need for a refraction and accept responsibility for the possible $50.00 fee for this service in addition to any co-payments, co-insurance, or deductible payments, and that I have had all my questions answered.

Initials:_____ Date:_____

CONTACT LENS AGREEMENT/CONSENT: (IF APPLICABLE)

By signing below, I certify that I have received, understand, and agree to the terms of the contact lens evaluation. I also understand and accept that I am responsible for any fees charged for these services in addition to any co-payments, coinsurance, or deductible payments, and that I have had all my questions answered.

Initials:_____ Date:_____

NOTICE OF PRIVACY PRACTICES, HADE EYE CARE, LLC AND PROTECTED HEALTH INFORMATION (PHI) DISCLOSURE:

By signing below, I certify that I have received and understand the Notice of Privacy Practices and consent to the use of my PHI as stated.

I authorize the following person to receive/discuss my PHI: _____

Print Name of Patient:_____ Date of Birth:_____

Signature of Patient or Legal Guardian:_____ Date:_____

FINANCIAL POLICY AGREEMENT/CONSENT:

By signing below, I certify that I have received and understand the financial policy of Hade Eye Care, LLC and assignment of benefits. I understand and agree that, regardless of my insurance status, I am ultimately responsible for all charges for professional services rendered to me, or my dependents. I agree to reimburse Hade Eye Care the fees of any collection agency, which may be based on a percentage at maximum 25% of the debt, and all costs, and expenses, including reasonable attorney's fees we incur in such collection efforts.

Print Name of Patient:_____ Date of Birth:_____

Signature of Patient or Legal Guardian:_____ Date:_____

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PATIENT INFORMATION

Name: _____ Social Security #: _____

Date of Birth: _____ Age: _____

Address: _____

_____

Home Phone #: _____ Cell Phone #: _____

Email: _____

Marital Status: (check one) ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Pharmacy: _____ Town: _____

Primary Care Physician: _____ Phone: _____

DUE TO NEW FEDERAL REGULATIONS, WE NEED TO ASK THE FOLLOWING:

Race/Ethnicity: ☐ Caucasian ☐ African American ☐ Asian/Pacific Islander ☐ Hispanic ☐ Native American

☐ Other: _____ Primary Language: _____

RESPONSIBLE PARTY: (please check) ☐ Self ☐ Other (please fill out requested information below)

Name: _____ Date of Birth: _____

Relationship: (check one) ☐ Parent ☐ Spouse ☐ Other: _____

Address: _____ Phone #: _____

PRIMARY INSURANCE:

Carrier: _____ Policy #: _____ Group #: _____

Policy Holder: _____ Date of Birth: _____

Social Security #: _____ Relationship: (check one) ☐ Self ☐ Parent ☐ Spouse ☐ Other: _____

Does your insurance require a referral? ☐ YES ☐ NO

SECONDARY INSURANCE:

Carrier: _____ Policy #: _____ Group #: _____

Policy Holder: _____ Date of Birth: _____

Social Security #: _____ Relationship: (check one) ☐ Self ☐ Parent ☐ Spouse ☐ Other: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Address: _____ Phone #: _____

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MEDICAL HISTORY

Name: _____ Date of Birth: _____

Primary Care Physician: _____

Allergies: _____

☐ Diabetes (type: _____)	☐ Cancer (type: _____)	☐ Multiple Sclerosis
☐ High Blood Pressure	☐ Thyroid Dysfunction	☐ Hepatitis C
☐ Heart Disease	☐ Stroke	☐ Lupus
☐ High Cholesterol	☐ Rheumatoid Arthritis	☐ Depression
☐ Asthma	☐ HIV	☐ Anxiety
☐ Emphysema	☐ Seasonal Allergies	☐ Rosacea
☐ Pregnant (Currently)	☐ OTHER(S): _____	

PREVIOUS MAJOR SURGERIES

_____ YEAR: _____

_____ YEAR: _____

_____ YEAR: _____

_____ YEAR: _____

_____ YEAR: _____

Please check (✔) if you are experiencing any of the following symptoms:

Constitutional	☐ None	☐ Fever	☐ Chills		☐ Other: _____
Neurologic	☐ None	☐ Dizziness	☐ Headache	☐ Numbness	☐ Other: _____
Heme/Lymph	☐ None	☐ Swollen Glands	☐ Clotting Problem	☐ Blood Transfusion	☐ Other: _____
Musculoskeletal	☐ None	☐ Joint Pain	☐ Neck Pain		☐ Other: _____
Gastrointestinal	☐ None	☐ Stomach Pain	☐ Nausea	☐ Vomiting	☐ Other: _____
Psychological	☐ None	☐ Depression	☐ Anxiety		☐ Other: _____
Cardiovascular	☐ None	☐ Chest Pain	☐ Heart Attack	☐ Heart Murmur	☐ Other: _____
Endocrine	☐ None	☐ Excess Thirst	☐ Excessive Fatigue	☐ Excessively Hot/Cold	☐ Other: _____
Respiratory	☐ None	☐ Short of Breath	☐ Wheezing	☐ Cough	☐ Other: _____
Skin	☐ None	☐ Rash	☐ Itch		☐ Other: _____
Genitourinary	☐ None	☐ Blood in Urine	☐ Pain with Urination		☐ Other: _____

MEDICATIONS

NAME	DOSAGE	TIMES A DAY	NAME	DOSAGE	TIMES A DAY
_____	_____	1 2 3 4	_____	_____	1 2 3 4
_____	_____	1 2 3 4	_____	_____	1 2 3 4
_____	_____	1 2 3 4	_____	_____	1 2 3 4
_____	_____	1 2 3 4	_____	_____	1 2 3 4

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes per day: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week: _____

Occupation: _____

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GLASSES/CONTACT LENSES

Do you wear Glasses? ☐ Yes ☐ No ☐ Readers Only Power: _____
If yes, Specify Type: ☐ Near ☐ Distance ☐ Progressive ☐ Bifocal

Do you wear Contact Lenses? ☐ Yes ☐ No
If you do, please supply the following: (This information can be found on your current CL box or blister pack)

RIGHT EYE: Brand: _____ Base Curve (B.C.): _____ Power (+, -): _____

LEFT EYE: Brand: _____ Base Curve (B.C.): _____ Power (+, -): _____

EYE DROPS

Name: _____ Eye: ☐ Right ☐ Left ☐ Both Times A Day: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Name: _____ Eye: ☐ Right ☐ Left ☐ Both Times A Day: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Name: _____ Eye: ☐ Right ☐ Left ☐ Both Times A Day: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Name: _____ Eye: ☐ Right ☐ Left ☐ Both Times A Day: ☐ 1 ☐ 2 ☐ 3 ☐ 4

CURRENT EYE PROBLEMS OR SYMPTOMS

☐ Blurred Distance Vision
☐ Blurred Reading Vision
☐ Double Vision
☐ Glare/Halos Around Lights
☐ Itching or Burning
☐ Flashing Lights/Floaters
☐ Red Eye
☐ Other: _____
☐ Foreign Body Sensation
☐ Tearing
☐ Dry Eye

YOUR PREVIOUS EYE HISTORY

☐ Cataract
☐ Glaucoma
☐ Macular Degeneration
☐ Retinal Detachment
☐ Eye Injury
☐ Other: _____
☐ Lazy Eye/Amblyopia
☐ Iritis/Uveitis

FAMILY HISTORY OF EYE DISEASES/PROBLEMS

(Limited to: Father, Mother, Sister, Brother, Grandparents)

☐ Cataract _____
☐ Glaucoma _____
☐ Macular Degeneration _____
☐ Retinal Detachment _____
☐ Blindness _____
☐ Iritis/Uveitis _____
☐ Crossed Eyes _____
☐ Other: _____

PREVIOUS EYE SURGERIES

Type: _____ Eye: ☐ Right ☐ Left Year: _____ Doctor: _____

Type: _____ Eye: ☐ Right ☐ Left Year: _____ Doctor: _____

Type: _____ Eye: ☐ Right ☐ Left Year: _____ Doctor: _____

Type: _____ Eye: ☐ Right ☐ Left Year: _____ Doctor: _____

HADE EYE CARE
COMPREHENSIVE OPHTHALMOLOGY

1 Indian Road, Suite 9, Denville, NJ 07834
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PATIENT ADVISORY AND ACKNOWLEDGEMENT

Receiving Medical Treatment During COVID-19 Pandemic

Dear Patient:

You have come to our office for a routine medical evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

- While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
- Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In an effort reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PLEASE ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS:

Are you currently awaiting the results of a COVID-19 test? ☐ Yes ☐ No

Have you been exposed to anyone who has been sick within the last 14 days? ☐ Yes ☐ No

Do you have a fever? ☐ Yes ☐ No

Do you have any shortness of breath? ☐ Yes ☐ No

Do you have a dry cough, runny nose, or sore throat? ☐ Yes ☐ No

Do you have sneezing, watery eyes, and/or sinus pain/pressure not related to seasonal allergies? ☐ Yes ☐ No

Have you experienced headaches, fatigue, or weakness? ☐ Yes ☐ No

Have you lost your sense of taste and/or smell? ☐ Yes ☐ No

Within the last 14 days, have you travelled to any foreign country? ☐ Yes ☐ No

Within the last 14 days, have you travelled within the United States? ☐ Yes ☐ No

If so, where? _____

Have you received the COVID-19 vaccine? ☐ YES: 1 dose ☐ YES: 2 doses ☐ NO

_____ _____

Patient Name/Responsible Party **Date**