

# Princeton Eye Group

## PLEASE PRINT ALL INFORMATION

Full Legal Name (last, first, middle initial) \_\_\_\_\_ Prefix/Suffix \_\_\_\_\_ / \_\_\_\_\_  
Address \_\_\_\_\_ Apt # \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Email \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_  
SS # \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex M / F Marital Status (please circle) S M D W  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Telephone # \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone # \_\_\_\_\_

Please List ALL Pertinent Medical History: \_\_\_\_\_

Family Medical History: \_\_\_\_\_

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: \_\_\_\_\_

PLEASE LIST ALL ALLERGIES: \_\_\_\_\_

Referring Physician \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip Code \_\_\_\_\_

### Responsible Party (if different than patient)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Email \_\_\_\_\_ Telephone # \_\_\_\_\_ Birthdate \_\_\_\_\_

DO YOU HAVE ROUTINE EYE EXAM (VISION) COVERAGE? Yes \_\_\_\_\_ No \_\_\_\_\_  
If so, Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Primary Insurance Company \_\_\_\_\_ Telephone Number \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Co-Pay Amount \$ \_\_\_\_\_ Deductible Amount \$ \_\_\_\_\_ Effective Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Telephone Number \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Co-Pay Amount \$ \_\_\_\_\_ Deductible Amount \$ \_\_\_\_\_ Effective Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_ Birthdate \_\_\_\_\_

I have completed this form and certify that I am the patient, or duly authorized agent of the patient. I understand that it is my responsibility to pay any deductible amounts and co-insurance. There are certain services, which are not covered by any insurance such as cosmetic procedures and routine eye exams (unless I have vision coverage). I understand that I will be responsible for payment for such non-covered services. **Medicare does not pay for routine eye exams or refraction (a necessary part of an eye exam to determine the need for glasses) to be medically necessary, therefore they do not cover these services.** I am expected to pay for these services at the time of checkout. I authorize release of medical information as may be required to substantiate or explain insurance claims filed. I authorize my insurance company to assign benefits to Princeton Eye Group. **I understand that if I have not provided Princeton Eye Group the correct insurance information, listed above, that I will be solely responsible for ALL services provided.** I permit a copy of this authorization to be used in place of the original. This authorization will remain in effect until revoked by me in writing. Under HIPAA Payment, Treatment and Options (TPO) I give permission to Princeton Eye Group to access Pharmacy Benefit Manager Information for management of prescriptions.

\_\_\_\_\_  
SIGNATURE OF PATIENT/GUARDIAN

\_\_\_\_\_  
DATE



Princeton Eye Group

Standardization for Health Care Quality Improvement:

Under the Affordable Care Act we are compelled to collect the specific information listed below to ensure that all patients throughout the country are treated fairly.

**This is required by the US Government not Princeton Eye Group.**

**Please review and provide the answers. Use the "Unknown/Not Reported" option if you prefer not to give this information.**

What is your race?  White  African American  Asian  
 American Indian  Native Hawaiian  
 Unknown/Not Reported

What is your ethnicity?  Hispanic or Latino  Non-Hispanic or Non-Latino  
 Unknown/Not Reported

What is your preferred language?  English  Spanish  
 Other \_\_\_\_\_

If you are 13 years of age or older, what is your smoking history?

Never  Current, somedays  Current, Everyday  Former

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date



**Princeton Eye Group**

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)  
AND  
PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVATE PRACTICES (NPP)

1. I understand that as part of my health care, Princeton Eye Group originates records and maintains protected health information (PHI) about me describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this PHI may be used or disclosed by Princeton Eye Group for treatment, payment and health care operations. For example, my health information serves as:
  - A basis for planning my care and treatment;
  - A means of communication among many health professionals who contribute to my care;
  - A source of information for applying my diagnosis and surgical information to my bill;
  - A means by which a third party payor can verify that services billed were actually provided; and
  - A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.
2. I acknowledge that I have been provided with Princeton Eye Group, Notice of Privacy Practices that provides a more complete description of the potential uses and disclosures of my PHI. I understand that I have the right to review the Notices of Privacy Practices prior to signing this consent. I understand that Princeton Eye Group reserves the right to change its Notice of Privacy Practices.
3. I understand that I have the right to request restrictions as to how my PHI may be used or disclosed to carry out treatment, payment or health care operations.
4. I understand that I may revoke this authorization in writing, except to the extent that Princeton Eye Group has already taken action in reliance on this consent. I will submit any revisions or revocation of this authorization in writing to Princeton Eye Group.
5. By signing this form, I consent Princeton Eye Group for the use and disclosure of my PHI for treatment, payment and health care operations.

\_\_\_\_\_ I give permission to discuss my medical record with:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ I give permission to leave detailed messages on my voicemail at the following number:

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_  
Name of Patient, Patient Representative or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient, Patient Representative or Legal Representative

\_\_\_\_\_  
Signature of Witness