Welcome to our office! Please complete this form in <u>black ink only</u> and return it to our receptionist. Please provide your insurance card & photo ID for a copy.

<u>Personal Information:</u> Date: ____/____/22

Name: _____ _____
Last First

Home Phone # _____ Cell Phone # _____

Mailing Address: _____
(No P.O. Box)

_____
City State Zip

SS#: _____ Date of Birth: _____ Age: _____

Sex: M F Marital Status: Single Divorced Married Widowed

Language: _____ Ethnicity: _____ Race: _____

<u>Insurance Information:</u>

What type of insurance do you currently have?

Medicare Medicaid Other None

<u>Primary Insurance Carrier</u>: _____

Primary Subscriber's Name: _____ **Date of Birth**:_____/_____/_____

ID# _____ Relationship to patient: _____

<u>Secondary Insurance Carrier</u>: _____

Primary Subscriber's Name: _____ **Date of Birth**:_____/_____/_____

ID#: _____ Relationship to patient: _____

<u>Employer Information:</u>

Employer: _____
(If retired, please list previous employer)

Employer's Address: _____

_____

Occupation: _____ Full or Part time / Retired

In case of emergency, please notify: _____

Person's relationship: _____ Phone # _____

Person's Address: _____

Information about Spouse:

Name: _____ Age: _____ Date of Birth_____

SS#: _____ Daytime Phone # _____

Employer and Address: _____

_____
(If retired, please list previous employer)

You were referred by: _____

Name of Your Family Physician: _____

Address: _____ City: _____

Phone #: _____

MEDICAL INFORMATION:

Today's visit is related to the following (please circle one):

Medical Problem Work Related Injury

Accident Related Motor Vehicle Injury

Routine Visit

Person Financially Responsible for this Bill:

_____
(Please Print)

_____
(Signature)

MEDICARE PATIENTS PLEASE KEEP IN MIND: You will be responsible for your yearly deductible and your co-payment/co-insurance (20%) at the time the service is rendered. As a courtesy, our office will file your claim with a secondary insurance carrier if it is a Medigap Participant.

I authorize any holder or other information about me to release to my insurance carrier or to the Centers for Medicare and Medicaid Services (CMS) or its agents, intermediaries or carriers, any information, including medical, needed to process this claim or a related Medicare claim. I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance or any health plan to: James E. Haberman, MD. I permit a copy of this authorization to be used in place of the original. This shall serve as a lifetime authorization, including Medicare. Any outstanding balance that is sent for collections will be charged an additional $75 fee.

_____ _____/_____/22

Patient's Signature Today's Date

James E. Haberman, M.D., F.A.C.S.
Excel Eye Care & Surgery Center

Date: ___/_____/ 22

Medical History Questionnaire

Medical History

Name: _____

List all major illnesses and injuries _____

_____

List any surgeries you have had _____

_____

List all illnesses, injuries and surgeries to the eye _____

_____

List any medications you take (including ocular) _____

_____

Do you have any allergies to medications? ___ Yes ___ No

If yes, list medication(s) _____

Review of Systems – Do you have any problems in the following areas? If yes, provide information.

Explanation of Problem

Constitutional Problems-Fever, weight loss _____

Eyes-Loss of vision, blurred vision, distorted vision (halos), _____

Loss of side vision, double vision, dryness, mucous discharge, _____

Redness, sandy or gritty feeling, itching, burning, tired eyes, _____

Glare/light sensitivity, eye pain or soreness, chronic infection, _____

Difficulty **with** night vision _____

Ears, nose, mouth, throat-Sinus congestion, runny nose, _____

Post nasal drip, chronic cough, dry throat/mouth _____

Cardiovascular-Palpitations, chest pain _____

Respiratory-Chronic bronchitis, shortness of breath _____

Explanation of Problem

Musculoskeletal-Arthritis _____

Psychiatric _____

Allergic-Head allergy symptoms, seasonal of hay fever _____

Family History

Disease	Yes	No	Relationship to Patient
Glaucoma	___	___	_____
Macular Degeneration	___	___	_____
Retinal Problem	___	___	_____
Arthritis	___	___	_____
Diabetes	___	___	_____
High Blood Pressure	___	___	_____
Stroke	___	___	_____
Tuberculosis	___	___	_____
Other	___	___	_____

Social History

Do you drive? ___ Yes ___ No Do you smoke? ___ Yes ___ No

Do you wear glasses? ___ Yes ___ No

Do you drink alcohol? ___ Yes ___ No If yes, ___ meals ___ socially __ other

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PHYSICIAN USE ONLY

History reviewed. ___ No changes. ___ Additions as noted above.

Signature: _____ Date: ___/_____/22

James E. Haberman, M.D., F.A.C.S.
Excel Eyecare & Laser Surgery Center

2333 Morris Avenue
Suite C-103
Union, New Jersey 07083
Tel. (908) 688-4000
Fax (908) 688-1717

Verification of Receipt of Health Information Privacy Practices

By signature below, I verify that I have received a copy of the Health Information Privacy Practices of James E. Haberman, M.D., P.A.

_____
Signature of Person or Personal Representative

_____
Date

_____
Printed Name of Person or Personal Representative

_____
Description of Personal Representatives Authority

James E. Haberman, M.D., F.A.C.S.
Excel Eyecare & Laser Surgery Center

Credit Card on File Agreement

FOR YOUR SAFETY, due to the COVID-19 National Health Emergency, our practice has implemented a new credit card policy. This is a safe, no-touch billing process for the future. We now will ask all patients for a credit card which may be used later to pay any balance that may be due on your bill.

If you choose not to leave a card or are unable to do so, the office will accept $200 toward the visit. After processing by your carrier, any credit remaining, will promptly be returned.

Co-pays are still due at the time of service.

At check-in your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. At that time, you will be sent a statement which you will have 30 days to pay in any fashion. After 30 days, if the bill remains unpaid, we will bill your credit card.

Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged.

If you have any questions about our policy, please do not hesitate to ask.

By signing below, I authorize James E. Haberman, M.D., P.A., to keep my signature and my credit card information securely on-file. I authorize James E. Haberman, M.D., P.A., to charge my credit card for any outstanding balances when due.

If the credit card that I provide today changes, or expires, please notify the office. If the credit card is denied for any reason, I agree to provide a new, valid card which can be charged over the phone and that the new card may be used with the same authorization as the original card. If we run your credit card and it is denied for any reason, we reserve the right to charge an additional $25 declined card fee if we are not able to run a new credit card within 7 days.

PATIENT NAME:_____ DOB:_____/_____/_____

CREDIT CARD AUTHORIZATION
VISA or MASTERCARD (circle one)

NAME (as it appears on credit card)_____

CREDIT CARD NUMBER_____

EXP. DATE_____/_____ CVV (3 DIGIT CODE ON BACK OF CARD)_____

BILLING ADDRESS OF CREDIT CARD_____
(Where your statement is mailed to)
_____

EMAIL ADDRESS:_____

AUTHORIZED SIGNATURE_____ DATE ___/___/__