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.

Personal Information: Date: ____/____/23

Name: ______________________________ ____________________________________
Last First

Home Phone # _______________________ Cell Phone # ________________________

E-Mail Address:____

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: ________________

Insurance Information:

What type of insurance do you currently have?

Medicare Medicaid Other None

Primary Insurance Carrier: ____

Primary Subscriber's Name: _______________________ **Date of Birth**:______/_______/______

ID# ______________________________ Relationship to patient: _____________________

Secondary Insurance Carrier: ____

Primary Subscriber's Name: _______________________ **Date of Birth**:______/_______/______

ID#: _____________________________ Relationship to patient: _____________________

Employer Information:

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

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.

_________________________________   _____/_____/23
Patient's Signature   Today's Date

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

Date:___/_____/ 23

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: ___/______/23

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 ___/___/__