

800 Wyckoff Avenue • Wyckoff, NJ 07481

Tel: 201-447-5454 • Fax: 201-447-8922

Welcome! We want your first visit with us at 800 Wyckoff Avenue in Wyckoff to go smoothly. Please arrive **15 minutes early to allow time to prepare your records**. You should expect your **first visit to take at least 1 hour**. This time may vary according to your individual needs.

Please bring the following:

1. Sunglasses for daytime exams
2. A list of all medications, including eye drops
3. Eyeglasses / Contact lens prescription. **Contact lens wearers should wear their contacts for the exam.**

We accept most major insurances. Please check with your plan about your coverage. Bring your insurance card and valid photo identification. If a referral is necessary, please bring that as well. Payment or co-payment is due at the time of your visit. For your convenience, we accept Visa, MasterCard, Cash or Check.

Please complete these forms and bring them with you as it will help expedite your visit. We will be happy to discuss any questions you may have during your visit. We look forward to seeing you.

Sincerely,

Patrick T. Clancy, M.D.

REGISTRATION FORM (Please Print)

DATE _____

Last Name: _____ First Name: _____ M.I. _____

Birthdate: ____/____/____ Age: _____ Gender: M F

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

(By signing this form I give permission to Dr Clancy's office to contact me via Home phone, Cell phone, Text and/or Email)

Primary Care Physician: _____

Employer Name & Address: _____

EMERGENCY CONTACT: _____ Phone: _____

Are you the person responsible for payment on this account? Yes No If no, fill in section below.

Name of person responsible for this account: _____

Relationship to patient: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: ____/____/____

INSURANCE INFORMATION

If injury was related to an accident, please circle one of the following: Work Related Auto Accident Other

Date of Accident: _____

Primary Insurance Information (Please provide insurance card(s) to Receptionist)

Insurance Company: _____

ID#: _____

Secondary Insurance Information

Insurance Company: _____

ID#: _____

Patient and/or Guardians Signature: _____ **Date:** _____

MEDICAL HISTORY QUESTIONNAIRE

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Pharmacy: _____ Pharmacy #: _____

Primary Reason for Today's Visit:

Routine/Annual Cataract Glaucoma Diabetes Dry Eye
 Macular Degeneration Blurred Vision Second Opinion Other: _____

Do you presently have any problems in the following areas:

	YES	NO		YES	NO
Loss or blurred vision	[]	[]	Respiratory (lungs, breathing)	[]	[]
Loss of side vision, double vision	[]	[]	Gastrointestinal (stomach, intestines)	[]	[]
Itching, burning, or discharge	[]	[]	Genitourinary (genitals, kidney, bladder)	[]	[]
Redness	[]	[]	Musculoskeletal (muscles, joints)	[]	[]
Gritty feeling, dryness or tearing	[]	[]	Integument (skin, breast)	[]	[]
Glare/light sensitivity or halos	[]	[]	Neurological (headache)	[]	[]
Eye pain or soreness	[]	[]	Psychiatric	[]	[]
Infection of eye lashes or lid, styes	[]	[]	Endocrine (hormones, glands)	[]	[]
Ears, Nose, Mouth, Throat	[]	[]	Hematologic/Immunologic (blood)	[]	[]
Cardiovascular (heart, blood vessels)	[]	[]	Seasonal Allergies (hay fever, etc)	[]	[]

PAST EYE HISTORY

	YES	NO
Eye drops currently in use (if yes, please list)	[]	[]
Allergies to eye drops (if yes, please list)	[]	[]
History of cataract, glaucoma, etc	[]	[]
History of lazy eye/eye muscle imbalance	[]	[]
Eye injury or other disease of the eye	[]	[]
Eye surgery (list on the lines to the right)	[]	[]

PAST MEDICAL HISTORY

	YES	NO		YES	NO		YES	NO
High Blood Pressure	[]	[]	Chronic Cough	[]	[]	Blackouts	[]	[]
Low Blood Pressure	[]	[]	Exposure to TB	[]	[]	Blood Disorder	[]	[]
Anemia	[]	[]	Asthma/Wheezing	[]	[]	Rheumatic Fever	[]	[]
Heart Murmur	[]	[]	Headaches	[]	[]	Meningitis, Polio	[]	[]
Heart Palpitations	[]	[]	Cancer	[]	[]	Bruising or Bleeding	[]	[]
Irregular Heart Beat	[]	[]	Stroke	[]	[]	Blood Clots	[]	[]
Pacemaker	[]	[]	Ulcer/Hiatal Hernia	[]	[]	Back Problems	[]	[]
Chest Pain/Angina	[]	[]	Thyroid Disease	[]	[]	Abnormal Chest X-ray	[]	[]
Sickle Cell Anemia	[]	[]	Nervous Disorder	[]	[]	Aids/HIV	[]	[]
Diabetes	[]	[]	Epilepsy/Seizures	[]	[]	Immune Deficiency	[]	[]
Hypoglycemia	[]	[]	Dizziness	[]	[]	Hepatitis/Liver Problems	[]	[]
Blindness	[]	[]	Kidney Problems	[]	[]	Heart Attack (date _____)	[]	[]
Deafness	[]	[]	Arthritis	[]	[]	Congestive Heart Failure	[]	[]
Shortness of Breath	[]	[]	Intestinal Disease	[]	[]	Bronchitis/Emphysema	[]	[]
Recent Cough/Cold	[]	[]	Psychiatric Disorder	[]	[]	Pneumonia/Lung Problems	[]	[]

Major illnesses not listed above: _____

Allergies to Medications: _____

List any medications that you are currently taking, or provide a printed list.

_____	_____	_____
_____	_____	_____
_____	_____	_____

List any major surgical procedures: _____

FAMILY HISTORY:

<u>OCULAR</u>	YES	NO	<u>MEDICAL</u>	YES	NO
Blindness	[]	[]	Diabetes	[]	[]
Cataract	[]	[]	Arthritis, Lupus, Etc.	[]	[]
Glaucoma	[]	[]	Other _____		
Macular Degeneration	[]	[]	_____		
Retinal Detachment	[]	[]	_____		

OUR OFFICE PHILOSOPHY

We feel it is extremely important to spend as much time as necessary with each patient to fully address various issues. This enables us to explain our findings and recommendations in depth and answer any questions you may have during your visit. Our staff schedules patients accordingly. Please be assured that we value your time. Given the unpredictable and sometimes emergent nature of eyecare, occasionally, there may be a prolonged wait time. Emergencies are unforeseen and need to be addressed as they arise. We do make every effort to see our patients in a timely manner. Our office is staffed to adequately meet the needs of our patients. If you need to cancel an appointment, please give us at least 24 hours notice. If you are going to be late, we need to be notified in order to remain on schedule.

Patient's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Office Financial Policy and Insurance Payment Disclosure

I authorize Patrick T. Clancy, MD PA to receive all insurance payments from my current medical insurance plan.

I agree to pay co-payments, deductibles, and non-covered fees at the time of service or upon first notification.

I agree to release all information necessary for my current insurance plan to process my claims.

Our office accepts cash, personal checks and credit/debit cards. In regards to payment by check: there is a \$35 fee for each check payment returned by your bank.

No Insurance:

I agree to pay in full at the time that services are rendered. The same applies if I have insurance and choose not to have the fees submitted to that insurance.

Private Insurance:

This office will accept "assignment of benefits" and will bill your insurance carrier. If applicable, we will also assist you in billing your secondary insurance carrier. However, deductibles and co-pays must be paid on the day of service. If your insurance carrier has not paid within 60 days of billing, all unpaid professional fees are due. These become your responsibility and payable in full by you.

Medicare:

We will bill Medicare for you. If you have a secondary insurance we will bill for you. Deductibles need to be paid on the day of service. Refraction fees are not covered by Medicare and must be paid by the patient that day.

Managed Care Insurance:

Some benefit plans require preauthorization and/or referrals to be examined by a specialist. You must provide insurance plan identification and forms required prior to your visit. You will be responsible for all payments that have not been authorized by the insurance or if the referral has not been made.

Referrals cannot be backdated by your doctor. Referrals are the responsibility of the patient. You must check with your insurance to find out if one is needed for a specialist.

Missed Appointment / Cancellation Policy:

Our goal is to provide excellent care for each patient in a timely manner. Therefore, we ask that you inform our office if you are unable to attend your scheduled appointment. This allows us to use that appointment time for another patient. If you need to cancel or re-schedule your appointment, please notify us at least 24 hours in advance. Failure to do so will incur a \$50 cancellation fee billed directly to you, not your insurance. Payment of this fee is required prior to your next appointment.

Contact Lenses:

Orders must be paid for at the time of pickup. We will issue a receipt to submit to your insurance upon request.

ASSIGNMENT OF INSURANCE BENEFITS – PLEASE READ AND SIGN BELOW:

I hereby assign all medical and/or surgical benefits, private insurance and any other health plans, to Patrick T. Clancy MD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. I have read and understand that I am financially responsible for all charges not paid by my insurance carrier. I hereby authorize said assignee to release all the necessary information to secure the payment. I have received a copy of The Notice of Privacy Practices from Patrick T Clancy M.D.P.A.

Patient or Guardians signature _____ Date _____ / _____ / _____