

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/Assignment

- I authorize Patrick T. Clancy, M.D. P.A. to bill and 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.
- I agree to pay in full at the time that services are rendered if I do not have insurance. The same applies if I have insurance and choose not to have the fees submitted to that insurance.
- This office will bill your insurance carrier. If applicable, we will also assist you in billing your secondary insurance carrier. All 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.
- Our office accepts cash, personal checks and credit/debit cards. In regard to payment by check: there is a \$35 fee for each check payment returned by your bank.
- 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. I accept responsibility 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.

PLEASE READ AND SIGN BELOW:

By signing this document, you are confirming you understand and agree you are providing Patrick T. Clancy M.D.P.A. and its affiliates, agents, and service providers including debt collectors with your express consent to contact you or the responsible party, including but not limited to contact via prerecorded messages, artificial voice messages, text or electronic messages and calls made by an automatic telephone dialing system, at any phone number or any cellular phone, which could result in charges to you, or other wireless device including any cellular phone number you currently have or will have in the future and at any e-mail provided for the purpose of contact in connection with resolution of this account. You agree that both the cell phone number(s) and/or e-mail address you provide belong to you, are secure and cannot be listened to or viewed by unauthorized third parties. I have received a copy of The Notice of Privacy Practices from Patrick T Clancy M.D.P.A.

Patient or Guardians signature:

_____ Date _____ / _____ / _____

4/23/2026

Limited Patient Authorization for Disclosure of Protected Health Information

Form 7.31

Please print all information. Form must be signed and dated.

Patient Name: _____ DOB _____ / _____ / _____

I **DO NOT** wish to have my health information disclosed to anyone at this time.

Entity Requested to Release Information: Patrick T Clancy M.D. P.A.

Who will be authorized to receive information - I authorize the entity identified above to disclose or provide protected health information about me to the Person or Facility listed below:

Name or Facility: _____ Phone: _____ Relation: _____

Name or Facility: _____ Phone: _____ Relation: _____

* **Secure Communication** - Note that some fax and email transmission methods are not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not include a recipient fax number or email address if this is of concern to you.

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

Entire patient record OR check **only** those items of the record to be disclosed:

- | | |
|---|--|
| <input type="checkbox"/> office notes | <input type="checkbox"/> nursing home, home health, hospice, and other physician records |
| <input type="checkbox"/> lab results, pathology reports | <input type="checkbox"/> record of HIV and communicable disease testing |
| <input type="checkbox"/> x-rays | <input type="checkbox"/> record of mental health or substance abuse treatment |
| <input type="checkbox"/> financial history report | |
| <input type="checkbox"/> Only disclose the following: _____ | |

- This authorization will expire when care is transferred to another provider, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Expiration if applicable: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

Patient or authorized representative signature

Date

You have the right to receive a copy of signed authorizations upon request.

4/30/2026