

◆
Neigel
Center
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101 Old Short Hills Road ◆ Suite 204 ◆ West Orange, NJ 07052 ◆ 973-325-7779 ◆ Fax: 973-325-7914

Your Appointment is scheduled for _____ @ _____ am/pm

Thank you for choosing The Neigel Center . We appreciate the confidence you have placed in us.

The referrals we receive through you and our other patients are highly valued and we do our utmost to earn them at every visit. Our entire staff is committed to providing you the finest medical and surgical care available in this area.

To provide you the best possible care and to assist you in obtaining all your insurance benefits under any medical plan, we need your assistance in completing the enclosed forms **(front and back)**. **Please bring these completed forms the day of your scheduled appointment in order to expedite your visit.** Providing us with this complete information regarding you, your past medical history and your medical insurance greatly facilitates your initial medical evaluation and the proper filing of insurance claims. We also ask that you bring your insurance card(s) and a photo ID with you. **Please note: If we do not participate with your insurance we will be happy to submit your claim as a courtesy however payment is expected in full on the day of service. Your insurance will reimburse you upon receipt of the claim.**

We understand that your time is valuable. We will make every effort to see you at your scheduled time, every time you visit. It is important to us that your time spent in this office is as informative and pleasant as possible. Understandably, our office routine is occasionally disrupted by surgery, emergencies, or prolonged and difficult problems that must take priority. We appreciate your understanding and patience when this happens and, as such, we promise to devote an equal amount of time and attention to your care.

DIRECTIONS TO OUR OFFICE

101 Old Short Hills Road (Atkins–Kent Building) is located across the street from St. Barnabas Medical Center. We are in Suite #204 on the second floor.

FROM GARDEN STATE PARKWAY (NORTH AND SOUTH): Go to exit #145 (The Oranges – Route 280 West), take 280 West to exit 10 (Northfield Avenue). From exit make a left, follow blue and white hospital signs to St. Barnabas Medical Center. Make left onto Northfield, and then turn left at Old Short Hills Road (Between Livingston Diner and Cleaners) Onto Old Short Hills Road. Atkins Kent Building 101 Old Short Hills Road is located across from St. Barnabas Medical Center.

FROM NEW JERSEY TURNPIKE (NORTH AND SOUTH): Take exit 15W to Route 280 West. (Follow above directions for exit 10, Northfield Avenue)

FROM ROUTE 287 (NORTH AND SOUTH): Exit at Route 10. Follow east to Livingston traffic circle, turn right at Northfield Avenue, follow blue and white hospital signs turning right (Between Livingston Diner and Cleaners). Onto Old Short Hills Road keep going until you seen the hospital on the right. 101 Old Short Hills Road is located across from St. Barnabas Medical Center.

FROM ROUTE 10 EAST OR MT. PLEASANT AVE. (RT.10 WEST): Route 10 to the Livingston traffic circle, turn right at Northfield Avenue, follow blue and white hospital signs turning right (Between Livingston Diner and Cleaners) Onto Old Short Hills Road. Atkins Kent Building 101 Old Short Hills Road is located across from St. Barnabas Medical Center.

FROM ROUTE 80 EAST: Exit at Route 280 East. Take exit 6 (Laurel Avenue So.), make right and follow blue and white signs. Bear left at fork to Shrewsbury Drive. Shrewsbury becomes East Cedar Street. Keep going straight through light crossing Northfield. We are on the left side at 101 Old Short Hills Road, across from hospital (approximately 3 miles from Rt. 280).

FROM ROUTE 80 WEST: 80 West to Garden St. Pkwy – follow above directions.

FROM ROUTE 78 WEST: Exit at Route 24 West. Continue to J.F.K. Parkway, following signs to Livingston. Turn right onto South Orange Avenue. Turn left at second traffic light onto Old Short Hills Road. Turn right at next light to 101 Old Short Hills Road in the Atkins Kent Building.

FROM ROUTE 78 EAST: Exit 49 A (Millburn/Springfield) 1st light (Main Street) turn right continue about 10 minutes – Main Street becomes Old Short Hills Road. We are on the right side.

Account # _____

The Neigel Center
101 Old Short Hills Road * Suite 204
West Orange, NJ 07052
Phone (973) 325-7779 Fax (973) 325-7914
Janet M Neigel MD, FACS * Martin Moskovitz MD FACS

Today's Date: _____

SS# _____ / _____ / _____ First Name _____ MI _____ Last Name _____

Street Address _____ City _____ State _____ Zip _____

County _____ Birthdate _____ / _____ / _____ Home Phone _____ Work Phone _____

Cell Phone: _____ Male Female Occupation: _____ Marital Status: S M D/S W

Email address: _____ @ _____ Driver's License # _____ State _____

Patient Employer _____ Pharmacy _____ Phone _____

By whom referred: _____ Address _____ Phone _____

Medical Doctor _____ Address _____ Phone _____

Ophthalmologist _____ Address _____ Phone _____

Emergency Contact _____ Relationship _____ Phone: H _____ Wk _____

RESPONSIBLE PARTY (Guarantor / Insured)

Person responsible for account _____ Relationship to patient _____

Address _____ Home Phone _____

Employer _____ Work Phone _____

Birthdate _____ / _____ / _____ SS# _____ / _____ / _____ Is this person currently a patient at this office? Yes No

INSURANCE INFORMATION SELF PAY COSMETIC

PRIMARY Insurance Co: _____ ID # _____ Group _____

Subscriber's Name _____ Date of Birth: _____ / _____ / _____ SS# _____ / _____ / _____

Relationship to patient _____ Subscriber's Employer _____ Co pay \$ _____

SECONDARY Insurance Co: _____ ID # _____ Group # _____

Subscriber's Name _____ Date of Birth: _____ / _____ / _____ SS# _____ / _____ / _____

Relationship to patient _____ Subscriber's Employer _____ Co pay \$ _____

WORKERS COMPENSATION MOTOR VEHICLE ACCIDENT DATE OF INJURY _____ / _____ / _____

Insurance Carrier & Address _____

Claim # _____ Name of Adjuster _____ Phone _____

FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT

I have been offered/received a copy of the Neigel Center HIPAA Privacy Notice. I authorize the Doctor(s), and staff of the practice as named on the reverse side of this form, to treat the patient named on this form and agrees to pay all fees and charges for such treatment. I authorize the physician to release any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits. I hereby authorize payment of insurance benefits to the doctor. I understand that I am financially responsible for all charges whether or not covered by said insurance. I understand that aesthetic (cosmetic) surgery is not a covered benefit of Medicare and other insurance carriers. Therefore any aesthetic procedure will be my financial responsibility and payment in full will be expected prior to the procedure. I authorize the Doctor(s), and staff of the practice as named on the reverse side of this form, to treat the patient named on this form and agrees to pay all fees and charges for such treatment. I agree to pay all charges for myself and members of my family per the terms of this agreement. Charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I agree that the prevailing party will be entitled to reasonable attorney's fees and costs as the Court determines proper. It is agreed that payments will not be delayed or withheld because of any lawsuits, liens or insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable. I understand that not all services and fees are covered by insurance. I understand that I am responsible for paying all deductibles, co-payments, non-covered services, and any portion of covered services not paid in full by my insurance. Such payments are due at the time of service or immediately upon presentation of the bill. I agree that I shall remain financially responsible for the above named patient until I notify you in writing to the contrary. This guarantee is continuing even if the actual patient, if a minor, reaches the age of majority. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my (the patient's) health or the above information. This instrument contains the entire and only agreement between the parties and there are no other promises, representations, or warranties, either expressed or implied. The provisions of these agreements shall not be changed or modified except for an instrument, in writing, signed by the parties hereto. You are entitled to a copy of this agreement at the time you sign. Keep it to protect your legal rights. NOTICE: DO NOT SIGN THIS AGREEMENT BEFORE YOU HAVE READ AND AGREED TO THE CONDITIONS SET FORTH ON THIS FORM. I consent to the photographing of my face and appropriated portions of my body and to the modification, use, display and publication of such photographs for medical, scientific, or educational purposes provided that I am not identified by name. I agree that the attending physician may use, or permit other persons to use any negatives, prints, movies, and digital images, and/or other visual or audio recordings, for purposes including, but not limited to, dissemination to health care professionals and/or members of the public for treatment, research, medical, scientific, teaching, or other purposes in such a manner as may be deemed appropriate by my attending physician. I agree that this information may be disseminated in either paper form or digital form using delivery techniques that include but are not limited to the U.S. Postal Service, Federal Express, UPS, email, the Internet, and file transfer protocol. A copy of this authorization shall be considered valid as the original.

X _____
Signature of patient or parent or guardian, if a minor Date

HIPPA COMPLIANCE

If the problem for which you are being seen for today requires a surgical procedure, our office has written patient authorization (available upon request) for Eltra (ambulatory surgical center) to:

1. () Leave pre-op instructions on the answering machine AND/OR 2. () Speak with _____ for pre-op instructions

Please provide a phone number where the nurse can reach you (the day) before your procedure: _____ Alternate # _____

X _____
Signature of patient or parent or guardian, if a minor Date

PATIENT NAME: _____

ACCOUNT # _____

DATE: _____

Reason for your visit today: _____

EYE HEALTH HISTORY

Age: _____ Last eye exam: _____ Glasses ? Yes No All the time Occasionally Reading Driving TV
Contacts: Yes No Type: _____ Hrs/Day _____

MARK "YES" OR "NO"

Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bloodshot Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blurred Vision-Distant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itching eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blurred Vision-Near	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lazy Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Light sensitive	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Color Vision-Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night Vision-Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Red Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Discharge from Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Halos	<input type="checkbox"/> Yes <input type="checkbox"/> No
Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Flashes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Temporary Vision Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Turned Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Twitching Eyelid	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Strain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting Spells, Blackouts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Watering Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Floaters or Spots	<input type="checkbox"/> Yes <input type="checkbox"/> No		

HEALTH HISTORY

Please mark "Yes" or "No" **and** indicate if you and/or a **blood relative** have had any of the following problems:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Mental illness	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Poor Color Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Retinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Drug Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Skin Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Emphysema/COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Thyroid Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Seasonal Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	*Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Heartburn/Hiatal hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Tobacco use? Amount _____	
Hepatitis (Type____)	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Alcohol use? Amount _____	
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Age: _____ Height: _____ Weight: _____	

Any additional illness or disease not listed above

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Medications (Including supplements)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Drug and Food Allergies

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

SURGERIES (List procedures and year)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Please answer the following and explain if "yes"

- Have you taken any cortisone or steroids in the past 6 months? Yes No _____
- Have you had any difficulty breathing? Yes No _____
- Have you ever had a problem with anesthesia? Yes No _____
- Do you develop keloid scars? Yes No _____
- Do you have any chipped/loose teeth, dentures, bridges, caps or braces? Yes No _____
- Do you have limited motion of a joint? Yes No _____
- Can you climb two flights of stairs? Yes No _____