METROPOLITAN EYE RESEARCH AND SURGERY INSTITUTE

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REGISTRATION FORM

PATIENT INFORMATION

Last name:	First name:	Middle:	☐Mr. ☐Mrs. ☐Ms.	Birth Date : / /	Age:	Sex: ☐M ☐F
Street address:		Social Security #:		Marital Status (circle one): Single / Married / Other		
City:	State:	ZIP Code:		Cell Phone #: ( ) –		
Preferred Language: ❑ English ❑ Español ❑ 中文	Email Address:			Home Phone #: ( ) –		
Primary Care Doctor (name and phone):		**Referring Doctor (name and phone):**				
Pharmacy (name, phone, and address):						

EMERGENCY CONTACT

Name:	Relationship to patient:	Cell or Home phone #: ( ) –

INSURANCE INFORMATION

Name of primary insurance:	Subscriber's name:	Birth Date:	Policy #:
Does your insurance require a referral to see a specialist? ☐ Yes ☐ No			
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Name of secondary insurance (if applicable):	Subscriber's name:	Birth Date:	Policy #:
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Metropolitan Eye Research and Surgery Institute or insurance company to release any information required to process my claims.

X _____ / /

Patient Signature Date

PATIENT PRIVACY DIRECTIVE

In our efforts to comply with the Health Insurance Portability and Account Activity (HIPAA), we need to be certain that we guard your privacy according to your wishes. Please provide the names and phone numbers of assigned person(s) to whom we may discuss the following matters:

1. Leave messages regarding appointments, treatments, and/or test results.
2. Discuss your appointments and billing issues.

_____ _____

Patient/Authorized Individual (please print) Phone number

I ACKNOWLEDGE I HAVE SEEN A COPY OF THE "NOTICE OF PRIVACY PRACTICES" POSTED IN THE OFFICE LOBBY. _____ **Initials**

NEXT PAGE

METROPOLITAN EYE RESEARCH AND SURGERY INSTITUTE
PRACTICE POLICY

TREATMENT CONSENT
I hereby authorize and consent to treatment at Metropolitan Eye Research and Surgery Institute. This may include the administration of medication, diagnostic tests and procedures as deemed necessary by my physician, or his assistants or designees, for purposes of diagnosis and treatment.

AUTHORIZATION & ASSIGNMENT
I authorize Metropolitan Eye Research and Surgery Institute and/or my physician to furnish information to my insurance carriers concerning my diagnosis and treatment. If I do not make payments in full services, I assign to Metropolitan Eye Research and Surgery Institute all payments for services rendered to my dependents or me.

MEDICARE CLAIMS
I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

PAYMENT GUARANTEE

PATIENT RESPONSIBILITY - I understand that I am responsible for any amount not covered by insurance, with no exception. I agree to provide payment within 30 days of notification by statement of this responsibility. Failure to do so will incur additional billing charges. This applies whether covered by HMO, PPO, or a traditional group health plan. I understand that Metropolitan Eye Research and Surgery Institute cannot bill my insurance company unless supplied with accurate and up-to-date insurance information and /or an original claim form. If my account becomes delinquent, I understand that it is subject for placement with an outside collection agency. A collection fee, not to exceed 30% of the unpaid balance including, but not limited to, collection agency fees, attorney's fees, filing fees, and court costs when necessary, will be added to the balance referred. If my account is placed with a collection agency, I understand that Metropolitan Eye Research and Surgery Institute may terminate availability of its services to me.

NON-PAYMENT AND ASSIGNMENT TO COLLECTION AGENCY - Metropolitan Eye Research and Surgery Institute offers flexible payment arrangements and would like to help settle any balances that are my responsibility in a prompt manner. If I am experiencing difficulty in paying my bill, it is my responsibility to contact the billing office to resolve my issue. Overdue patient and insurance balances may be submitted for collections activity of non-payment. I am aware that any account assigned for collection activity cannot be "removed" from collections once it has been placed with the collection agency.

CONTRACTED INSURERS - If Metropolitan Eye Research and Surgery Institute participates (is contracted) with my insurance plan, it will file claims as a courtesy to me. I will be responsible for: co-payments, coinsurances, annual deductibles, non-covered services.

NON-COVERED SERVICES - Insurers routinely state, "The determination of coverage is made at the time the claim is submitted." Providers often do not know if treatments will be covered until they receive the insurer's EOB(explanation of benefits). After the EOB for my submitted claim has been received at Metropolitan Eye Research and Surgery Institute, I will be billed for any items not covered by my insurance plans. Services may be denied for coverage because the carrier considers the services: 1) medically unnecessary, 2) preexisting condition, or 3) cosmetic. In the event that Medicare or any insurance carrier should deny payment, I agree to be personally and fully responsible for payment.

TRANSFER OF CREDIT BALANCE - A credit balance resulting from payment to Metropolitan Eye Research and Surgery Institute from insurance or other sources may be applied to any other accounts owed by the insured and/or family of the insured.

PATHOLOGY AND LABORATORY CHARGES - Final laboratory charges cannot be anticipated at the time of service and are not within our control. Clinical laboratories will perform all needed tests to clarify or confirm a diagnosis. This can result in significant additional fees. I will be responsible for any amount not covered by insurance.

FEES

CO-PAY REBILLING CHARGE - Metropolitan Eye Research and Surgery Institute's contract with my insurer requires them to collect any co-payments in full at the time of service. If, for any reason, the correct co-pay is not collected at the time of service, a $10.00 service charge will apply for additional billing to collect co-pay.

RETURN CHECKS - A $35.00 processing fee will be charged for returned checks. Returned checks may also be forwarded to Metropolitan Eye Research and Surgery Institute's collection agency for further action.

APPOINTMENT CANELLATION OR "NO SHOW" - As a courtesy, the office has an automated appointment reminder system that calls 2 days before and a day before to verify my appointment. This provides adequate time to cancel or change my appointment if needed. 24-hour notice is required to avoid the $25.00 late cancellation or no-show charge. This charge is not billable to any insurance carrier.

MEDICATION REFILLS Patients are given enough medication to sustain them until their next visit. A follow-up visit is usually required for prescriptions written over 6 months ago. Depending on the medication, a one-time refill may be given.

NO INSURANCE CARD If I arrive without my insurance card for my first visit. I will be charged the standard commercial fee. Metropolitan Eye Research and Surgery Institute is not able to provide an insurance discount or contracted fee without that card and supporting identification. No refunds or insurance discounts will be provided after the fact. Refund of the full amount patient paid is done only after the insurance pays.

A copy of this authorization shall be valid as the original.

_____
Print name of patient / legal representative

X _____ / / _____
Signature of patient / legal representative **Date**

METROPOLITAN EYE RESEARCH AND SURGERY INSTITUTE MEDICAL QUESTIONNAIRE

Patient Name: _____ **Date of birth:** _____ **Date:** _____

Describe the reason that you were referred here. Include your history of present illness and their locations, quality, severity, time, modifying factors, associated signs and symptoms and duration:

What makes it better/worse? Is there any other information that you feel is important:

Please list **all eye operations** that you have had (including laser surgery) and the dates of the surgeries.

Please list **all other operations and hospitalizations** that you have had with the dates and locations.

Please list **all medications** you are currently taking, including their **dosages.** Be sure to include prescription drugs, eye drops, non-prescription drugs such as aspirin, Advil, antihistamines, vitamins, and supplements.

Please list **all medical conditions** past or present.

Do you have any allergies? ☐ **Yes** ☐ **No**

If yes, please list **all allergies** including medication, food, and environmental allergies that are known to you.

Social History:

Do you smoke? vape? ☐ YES ☐ NO If **YES**, how much?_____/daily & since ____years ____months

Did you ever smoke? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO If **YES**, how much? _____

Please check ✓ one best answer to each question:

How often do you exercise:
- ☐ Never
- ☐ A few times/month
- ☐ A few times/week
- ☐ Once a day
- ☐ Other

What is your caffeine use:
- ☐ Never
- ☐ A few times/month
- ☐ A few times/week
- ☐ Once a day
- ☐ Several times a day

Driving Status:
- ☐ Drives in the daytime
- ☐ Drives at night
- ☐ None

Have you ever received Pneumonia vaccination? (Over 66 years old **ONLY**) ☐ YES ☐ NO

Occupation & Workplace: _____

Have you lived outside of the USA? ☐ YES ☐ NO If **YES**, where? _____

List dates of previous MRI or CT scan of Head: If **YES**, please bring results and films of last scan.

Do you have a known contraindiction to having a scan ☐ YES ☐ NO

To having contrast/dye ☐ YES ☐ NO

Do you have metal in your body other than your mouth ☐ YES ☐ NO

Family History:

These questions refer to your grandparents, paretns, aunts, auncles, brothers, and sisters, children, or grandchildren.
Has anyone in your family had?

	Yes	No		Yes	No
Cancer	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Sickle Cell Disease	☐	☐
Allergies	☐	☐	Lyme Disease	☐	☐
Arthritis or Rheumatism	☐	☐	Gout	☐	☐
Multiple Sclerosis	☐	☐	Heart Disease	☐	☐
High Blood Pressure	☐	☐	Stroke	☐	☐
Inheritable disease	☐	☐	High Cholesterol	☐	☐

Has anyone in **your family** had medical problems of the:

	Yes	No		Yes	No
Eyes	☐	☐	Stomach or Bowels	☐	☐
Skin	☐	☐	Nervous System or brain	☐	☐
Kidneys	☐	☐	Glaucoma	☐	☐

NEXT PAGE

Review of Systems: Please check ✓ all that apply

General:	Yes	No
Chills	☐	☐
Night Sweats	☐	☐
Poor Appetite	☐	☐
Do you feel sick?	☐	☐
Fevers (persistent or recurrent)	☐	☐
Fatigue (tired easily)	☐	☐
Unexplained weight loss	☐	☐
Chronic swollen glands	☐	☐

Head:	Yes	No
Frequent or severe headaches	☐	☐
Numbness or tingling in body	☐	☐
Seizures, convulsions or epilepsy	☐	☐
Loss of consciousness	☐	☐
Speech difficulties	☐	☐
Double Vision	☐	☐
Fainting	☐	☐
Paralysis in parts of your body	☐	☐
Stroke	☐	☐
Imbalance/poor coordination	☐	☐
Sudden or severe loss of vision	☐	☐
Brain tumor or hemorrhage	☐	☐

Ears:	Yes	No
Hard of hearing or deafness	☐	☐
Frequent or severe ear infection	☐	☐
Ringing or noises in your ear	☐	☐
Painful or swollen ear lobes	☐	☐

Nose and Throat:	Yes	No
Sores in your nose or mouth	☐	☐
Dry mouth	☐	☐
Frequent sneezing	☐	☐
Persistent hoarseness	☐	☐
Nasal/respiratory allergies	☐	☐
Neck Pain	☐	☐
Severe or recurrent nosebleeds	☐	☐
Sinus trouble	☐	☐
Tooth or gum infections	☐	☐
Chronic or frequent sore throats	☐	☐
Restricted neck movement	☐	☐

Skin:	Yes	No
Rashes	☐	☐
Sunburn easily	☐	☐
Loss of hair	☐	☐
Painfully cold fingers	☐	☐
Raynauds	☐	☐
Skin sores	☐	☐
White patches on skin or hair	☐	☐
Tick or insect bites	☐	☐
Severe itching	☐	☐

Respiratory:	Yes	No
Severe/frequent colds	☐	☐
Coughing up blood	☐	☐
Wheezing or asthma attacks	☐	☐
Pneumonia	☐	☐
Constant coughing	☐	☐
Recent flu or viral infection	☐	☐
Difficulty breathing	☐	☐
Emphysema	☐	☐

Cardiovascular:	Yes	No
Chest pain	☐	☐
Swelling in legs	☐	☐
Irregular heart rhythm	☐	☐
Pacemaker	☐	☐
Do you snore abnormally	☐	☐
Shortness of breath	☐	☐
Heart Attack/failure	☐	☐
Palpitations	☐	☐
High Blood Pressure	☐	☐
Do you have sleep apnea	☐	☐

Blood:	Yes	No
Swollen lymph nodes/glands	☐	☐
Ever received blood transfusions?	☐	☐
Leukemia	☐	☐
Frequent or easy bleeding	☐	☐
Anemia	☐	☐
Clotting Tendency	☐	☐

Immunologic/Infections:	Yes	No
Unusual susceptibility to infection	☐	☐
Venereal disease	☐	☐
Tuberculosis	☐	☐
AIDS/ARC/HIV	☐	☐

Gastrointestinal:	Yes	No
Trouble swallowing	☐	☐
Bloody stool	☐	☐
Jaundice or yellow skin	☐	☐
Frequent abdominal pain/cramp	☐	☐
Diarrhea	☐	☐
Stomach ulcers	☐	☐
Constipation	☐	☐
Hepatitis	☐	☐

Bones and Joints:	Yes	No
Stiff joints or lower back	☐	☐
Pain with chewing	☐	☐
Muscle aches	☐	☐
Fractured bones	☐	☐
Painful or swollen joints	☐	☐
Back pain while sleep/awakening	☐	☐
Herniated disc	☐	☐
Pain or tenderness of scalp	☐	☐

Genitourinary:	Yes	No
Kidney disease	☐	☐
Blood in your urine	☐	☐
Genital sores or ulcers	☐	☐
Testicular pain	☐	☐
Do you plan to become pregnant?	☐	☐
Are you pregnant	☐	☐
Bladder trouble	☐	☐
Urinary discharge	☐	☐
Prostatis	☐	☐

Endocrine/Hormonal:	Yes	No
Thyroid disease	☐	☐
Diabetes	☐	☐

If yes, when diagnosed? _____
Latest HbA1c _____
Fasting blood sugar level _____

Psychiatric:	Yes	No
Severe Depression	☐	☐
Treatment for psychiatric disorders	☐	☐
Severe mood swings	☐	☐
Medication for depression/anxiety	☐	☐