



North Shore Medical and
Surgical Eye Care, P.C.
260 Middle Country Road
Suite 201
Smithtown, NY 11787

631-265-8780
Fax: 631-265-8521
www.nseye.com

Sidney Martin, MD
Comprehensive Ophthalmology

Lawrence Zweibel, MD FACS
Comprehensive Ophthalmology
Cataract Surgery
Laser Vision Correction

Jeffrey Martin, MD FACS
Comprehensive Ophthalmology
Cataract Surgery
Laser Vision Correction

John Mauro, DO
Comprehensive Ophthalmology
Cataract Surgery
Laser Vision Correction
Uveitis

North Shore Eye Care

We Build Relationships For Life.

Welcome!

Dear Patient:

Thank you for scheduling an appointment with NORTH SHORE EYE CARE. This letter confirms your appointment and provides valuable information about our office policies. Please read this letter and contact us if you have any questions; we want to make your time with us enjoyable and productive. To learn more about our physicians, please feel free to visit our website at <http://nseye.com>.

Preparing for the visit

Please complete the enclosed patient information and clinical history form and please bring the forms with you at the time of your appointment. Please do not send them back in the mail. Completing this information ahead of time allows us to try our hardest to get you seen by the doctor as soon as possible, and ensures we have the information necessary to fully address your health care needs.

In addition, please bring the following with you:

- A photo ID
- Your insurance card(s)
- A referral (if required by your insurance plan)
- A list of any medications you are currently taking
- The name and phone number of the physician or optometrist who referred you

We look forward to becoming your eye-care professionals, and take great pride in this responsibility. We welcome your comments, and ask you to contact us if there is anything we can help you with either before or after your appointment.

Sincerely,

The Doctors at NORTH SHORE EYE CARE

PATIENT INFORMATION

Patient Name: _____ Age: _____ Date of Birth: _____

Address: _____
(Street) (City) (State) (Zip)

Social Security Number: _____ Sex: M/F Marital Status: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

E-Mail Address: _____

Your Employer/School: _____

In Case of Emergency, Whom Should We Contact? _____

Phone Number: () _____ Relationship: _____

Family Doctor: _____ Phone Number () _____

Pharmacy Name: _____ Pharmacy Number: () _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

ARE YOU INTERESTED IN REDUCING OR ELIMINATING THE NEED FOR GLASSES OR CONTACT LENSES? _____ YES _____ NO

North Shore Eye Care
Assignment of Benefits

- I hereby assign, transfer, and set over to the above named physician group and facility sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, and/or others who are financially liable for the cost of care and treatment rendered to the patient.
- I authorize the above named physician group and facility to release any and all records, medical history, services rendered, or treatment given to the patient for purpose of review, investigation, or evaluation of any claim submitted to my insurer(s).
- I authorize the transferring of any and all necessary personal medical or demographic information required by the pharmacist in order to fill or refill medication prescriptions. I understand that this information may be transferred electronically, verbally, or in writing.
- I agree that I am financially responsible for any balance that my insurance does not cover for services or treatment rendered to the patient. I agree that if the patient is not covered by medical insurance, then I am responsible for all charges for services or treatment rendered to the patient.

I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient Signature: **X** _____ Date: _____

(If Minor, Parent/Guardian)

INSURANCE FACT SHEET

PRIMARY INSURANCE:

Insurance Company: _____ Co Pay Amount: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Date of Birth: _____

Social Security #: _____ Relationship to Patient: _____

Policy Holders Employer: _____

SECONDARY INSURANCE:

Insurance Company: _____ Co Pay Amount: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Date of Birth: _____

Social Security #: _____ Relationship to Patient: _____

Policy Holders Employer: _____

TERTIARY INSURANCE:

Insurance Company: _____ Co Pay Amount: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Date of Birth: _____

Social Security #: _____ Relationship to Patient: _____

Policy Holders Employer: _____

DATE: _____

NORTH SHORE EYE CARE – 260 MIDDLE COUNTRY ROAD, SUITE 201, SMITHTOWN, NY 11787

NOTICE OF PRIVACY PRACTICES

The purpose of this notice is to describe how your medical information is used, whom it is disclosed to and how you gain access to it.

The medical group as a healthcare provider is permitted by law to collect, use, and disclose your “protected health information” or medical record for the purpose of treatment, payment, internal business operations, or as required by law for reporting purposes.

You have certain rights including access to your information and some control over who has access to your information.

North Shore Eye Care agrees to abide by the terms of this notice but reserves the right to change the terms at any time. Should we do so, we will notify you in writing.

1. Use and Disclosure of Protected Health Information: When you sign a consent form to be treated, your protected health information is used to treat you, to bill you or your insurance company for your care and to make decisions on how to provide healthcare services for you, your family, and the community we take care of. Your physician, office staff and others outside of the medical group i.e. your insurer are allowed access to this information. Some examples of uses and disclosures of your protected health information are for:

- Treatment by your doctor
- Payment for your treatment by you or your insurance
- The medical group to determine if we meet the needs of our patients
- Reporting adverse events of medications or medical devices to the FDA
- Reporting public health risks
- Appointment reminders
- Law enforcement
- Coroners, Funeral Directors
- Worker’s Compensation
- Organ or tissue donation

2. Your Rights Regarding Your Protected Health Information

- You have the right to inspect and to obtain a copy of your protected health information for as long as the group maintains you record.
- You have the right to restrict or limit the use of your protected health information that we use for treatment, payment, or operations. You can restrict the release of your health information to family or friends unless they have your written or verbal permission.
- You have the right to request an accounting of disclosures made of your health information.
- You have the right to amend your protected health.
- You have the right to request confidential communications as long as it’s done in writing.
- To amend your health information, your request must be given in writing along with a reason for doing so. Your request can be denied if the information originated outside North Shore Eye Care; it is outside the information you are entitled to inspect or copy or if the information in the record is correct.
- For example, you can specify that we only contact you at work, at home, or by mail, etc.

If you feel your privacy rights have been violated, you may file a complaint, which will be forwarded to our Compliance Officer

ACKNOWLEDGEMENT OF RECEIPT OF NORTH SHORE EYE CARE’S PRIVACY PRACTICES

I, the undersigned, acknowledge that I have received a copy of the North Shore Eye Care’s Notice of Privacy Practices. Should I have any questions about the policy, I will discuss them with my physician or the group’s Compliance Officer.

Signature: **X** _____ Date: _____

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Date of Birth: _____ Date of last eye exam: _____

List any medications you currently take (prescription and over the counter):

Are you allergic to any medications? YES _____ NO _____

If yes, please list medications:

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.), or injuries (concussions, etc.)

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.)

Do you currently have any problems in the following areas? If yes, please provide information.

	YES	NO	EXPLANATION OF PROBLEM
Eyes (glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucus discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			

GENERAL/CONSTITUTIONAL	YES	NO	EXPLANATION OF PROBLEM
Fever			
Weight loss			
Other			
Ear, Nose, Throat (sinus, ear infection, chronic cough, etc.)			
Cardiovascular (heart, vessels, etc.)			
Respiratory (Asthma, emphysema, etc.)			
Gastrointestinal (Stomach ulcers, intestinal disease, etc.)			
Genital, Kidney, Bladder			
Muscles, Bones, Joints			
Skin (Acne, warts, skin cancer, etc.)			
Neurological (Multiple Sclerosis, etc.)			
Psychiatric (anxiety, depression, etc.)			
Endocrine (Diabetes, hypothyroid, etc.)			
Blood/Lymph (cholesterolemia, anemia, etc.)			
Allergic/Immunologic (Hay fever, lupus, Sjogrens, etc.)			

FAMILY HISTORY

M=MOTHER

F=FATHER

S=SIBLING

GP=GRANDPARENT

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney Disease			
Lupus			
Stroke			
Thyroid disease			
Other			

Social History

Current Occupation: _____

Marital Status: (Married, Divorced, Single, Widowed)

Do you drive? ___ YES ___ NO

Do you have visual difficulty when driving? ___ YES ___ NO

Do you have problems with night vision? ___ YES ___ NO

Have you ever worn contact lenses? ___ YES ___ NO

If yes, how long have you work contact lenses? _____

Do you currently wear glasses? ___ YES ___ NO

If yes, how long have you had the current prescription? _____

Do you drink alcohol? ___ YES ___ NO If yes, how often? Occasionally 1 glass per day 2-3 per day 4+ per day

Do you smoke? ___ YES ___ NO If yes, how often? Occasionally ½ pack per day 1 pack per day 2+ pack per day

Have you ever had a blood transfusion? ___ YES ___ NO

History Reviewed _____ No changes _____ Additions as noted above _____

Physician's signature

Date: