

THE LOW VISION CENTER AT ROBERT WOOD JOHNSON

Name	Sex: M F
Address	
Phone Number	
E-Mail Address	
Date Of Birth	
Social Security #	
Emergency Contact	

Who referred you to the Low Vision Center?

-- OCULAR HISTORY --

What is the reason for your vision problem?

When was this initially diagnosed?

Have you received any treatment for this condition?
(Please list any procedures, with dates performed, and doctor who performed procedure)

Do you have any other eye conditions?

Have you had any other eye surgeries?
(Please list, with dates performed, and doctor who performed procedure)

Are you using any medications or nutritional supplements for your eyes (please list)?

Do you experience double vision?

Have you experienced a sudden loss in your vision (blackout)?

Do you experience eye pain or discomfort?

Patient Name:
Date of Exam:

-- VISUAL HISTORY --

To the best of your ability, please describe your vision.

Do you feel that your vision is stable? Getting better? Getting worse?

Which eye do you feel sees better?

Do you currently wear glasses? (Circle One) Distance Near Both

Do you feel that your glasses help you?

Are you currently using magnifiers or other visual aids (please list)?

Is glare a problem?

Do you live alone?

Do you handle your own finances?

What are your hobbies and interests?

Have you had a low vision evaluation before?

GOALS

Please list activities that you are no longer able to do because of your vision that you would like to be able to do again. Please be specific as possible (i.e. Instead of "reading", tell us exactly what you would like to read.)

If you had to choose one activity on the above list that you would consider "top priority", which would you choose?

Are there any other issues about yourself or your vision that you feel the doctor should be aware of?

Patient Name:
Date of Exam:

-- MEDICAL HISTORY --

(Check the box and list approximate duration of condition)

	NO	YES	DURATION
Diabetes			
High Blood Pressure			
High Cholesterol			
Heart Disease			
Kidney Disease			
Thyroid Disease			
Gastrointestinal			
Neurological (Brain)			
Skin Condition			
Arthritis			
Lung or Respiratory Problem			
Cancer			
Stroke			
HIV/Infectious Disease			
Alcohol or Drug Abuse			
Other (please specify)			

List all medications you are currently taking:

Allergies to medications:

Do you currently smoke?

If yes, how many packs a day?

Do you currently drink alcohol?

If yes, how many glasses a day?

Patient Name:
Date of Exam:

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITIES:

1. Reading labels on your meds?	Yes	No	Gave Up
2. Reading newspaper print?	Yes	No	Gave Up
3. Reading your mail/bills?	Yes	No	Gave Up
4. Seeing prices and labels?	Yes	No	Gave Up
5. Reading handwritten notes?	Yes	No	Gave Up
6. Seeing colors?	Yes	No	Gave Up
7. Seeing to sew/knit/crochet or play cards?	Yes	No	Gave Up
8. To do your housework?	Yes	No	Gave Up
9. To cook/see stove dials?	Yes	No	Gave Up
10. To see the food on your plate?	Yes	No	Gave Up
11. To cut fruits and vegetables?	Yes	No	Gave Up
12. To dial and use a phone?	Yes	No	Gave Up
13. To groom yourself?	Yes	No	Gave Up
14. To see a computer screen?	Yes	No	Gave Up
15. Writing/signing your name?	Yes	No	Gave Up
16. To write checks/pay bills?	Yes	No	Gave Up
17. Seeing curbs and stairs?	Yes	No	Gave Up
18. Seeing faces?	Yes	No	Gave Up
19. Seeing the TV?	Yes	No	Gave Up
20. Seeing at the theatre or sports events?	Yes	No	Gave Up
21. Seeing to drive a car?	Yes	No	Gave Up
22. Seeing traffic lights or street signs?	Yes	No	Gave Up
23. Crossing streets?	Yes	No	Gave Up

Patient Name:
Date of Exam:

If you are using insurance, please complete the following information:

Patient Name _____

Patient Date of Birth _____

Marital Status: Single Married Other _____

PRIMARY INSURANCE:

Company: _____

Insured's Name: _____

Insured's Date of Birth: _____

Relationship to Insured: Self Spouse Other _____

SECONDARY INSURANCE:

Company: _____

Insured's Name: _____

Insured's Date of Birth: _____

Relationship to Insured: Self Spouse Other _____

I request that payment of authorized Medicare or other insurance benefits be made either to me or on my behalf to Low Vision Center at Robert Wood Johnson c/o Somerset Eye Care for any services furnished to me by the Low Vision Center at Robert Wood Johnson c/o Somerset Eye Care. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service.

I understand that the financial responsibility for the account is mine, not the insurance company's. I understand that any balances not covered by insurance are my sole responsibility, and that if my account is sent to a collections agency due to unpaid balances, then a \$30 collection fee will be added to my account.

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician for services rendered. I have read and understand the Notice of Privacy Practices for Somerset Eye Care, and understand that Somerset Eye Care will release my protected health information only as allowed by law.

Beneficiary Signature

Date

Patient Name:
Date of Exam:

THE LOW VISION CENTER AT ROBERT WOOD JOHNSON
125 Paterson Street, 4th Floor
New Brunswick, NJ 08901
(732) 568-0038

Low Vision Device Policy

Low vision aids vary greatly in quality, and in cost. These devices are not covered by Medicare or most other insurances. The cost of the devices is the responsibility of the patient. Please let the doctor know if you feel you will not be able to afford the low vision devices— in some cases there are state agencies that can offer assistance.

You will be informed of the cost of the low vision aids that are recommended for you. If a device is being mailed to you, full payment is due at the time of order.

For custom-made devices, once the device is received at the Low Vision Center, you will be contacted by phone, mail, and/or e-mail. You must pick up the device within 30 days of notification. If you do not pick up the device within 30 days, it will be returned to the manufacturer, and you may lose your deposit.

Once you receive your low vision device, if you are not satisfied, the device can be returned within 14 days. For devices returned within 14 days, you will receive a refund (or credit) for the full cost, minus a 10% restocking fee, provided the device is returned in a timely manner, in good condition with all packing material intact. If the device is returned between 14 and 60 days, you will receive a 50% refund. No refund is given for devices held longer than 60 days. Shipping charges are not refundable.

Date of Evaluation:

Devices Ordered	Cost

Amount Paid:

Expected Delivery Date of Vision Aids:

Balance Due:

I understand and accept the policy as stated above.

Patient Signature

Patient Name:
Date of Exam: