THE EYE CENTER
OPHTHALMIC ASSOCIATES, P.A.

Attention: The Eye Center- Dr. Christopher Bruno will be relocating on 11/18/2024 to 1051 West Sherman Ave Building 5, Suite A Vineland, NJ 08360
STRAIGHT BACK TO THE LEFT

Christopher R. Bruno, M.D.
1051 West Sherman Ave
Building 5 Suite A
Vineland, NJ 08360
www.EyeCenterVineland.com
Tel: 856-696-0020
Fax: 856-205-1721

PLEASE USE BLACK PEN ONLY

Your appointment at The Eye Center has been scheduled for:

_____at _____am/ pm with Dr. Bruno

Prior to your appointment, please complete the attached forms and bring them with you on the day of your appointment. if you would like to minimize your wait time, please bring forms and all listed below prior to your appointment.

You will also need to bring the following:

- Photo ID
- Insurance card
- List of current medications
- Referral, if your insurance carrier requires one
- Please be prepared to pay for your visit with cash or credit card. Sorry we **do not accept checks from new patients**. We apologize for any inconvenience.
- Self-pay patients are required to bring a photo ID for identification purposes and payment is due at the time of the visit.

Please note:

- You may be in the office for 1 to 2 hours.
- You may be dilated. (This causes you to be light sensitive and blurry for a few hours. Please bring a driver and sunglasses.)

*If you would like to **minimize your wait time** in the office, please feel free to drop off your completed paper work, photo ID and Insurance cards **1-2 weeks prior** to your appointment. (Please do not mail back as the mail has been delayed or can get lost)*

Should you need to reschedule or cancel your appointment, please call 696-0020 at least 24 hours in advance of your scheduled appointment.

Thank you,
Christopher R. Bruno, M.D.

Welcome!

Patient Information

Today's Date _____ **Soc. Sec. #** _____ **Birth Date** _____
Name _____ **Home Phone** _____
Address _____ **Cell Phone** _____
City _____ **State** _____ **Zip** _____ **E-mail** _____
Sex: ☐ M ☐ F **Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race: ☐ Asian ☐ African American ☐ American Indian or Alaska Native ☐ Hispanic

☐ Native Hawaiian or another Pacifica Island ☐ White ☐ Declined to Specify

Language: ☐ English ☐ Other ☐ Sign Language ☐ Spanish ☐ Declined to Specify

Ethnicity: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ Declined to Specify

Insurance Company_____ **Member ID #**_____
2nd Insurance Company: _____**Member ID #**_____

Emergency contact _____**Relation** _____ **Tel.** _____

Patient's Family Physician _____ **Tel.** _____
Pharmacy: _____**City**: _____

☐ **Employed** ☐ **Retired** ☐ **Full Time Student** ☐ **Part-Time Student** ☐ **Unemployed**
Employer _____ **Business Phone** _____
Business Address _____ **Occupation** _____

Who should we thank for referring you?
Patient Name _____ Physician's Name_____
Insurance Handbook ___ Newspaper ___ Telephone Book ___ Other _____

If Patient is Minor
Parent(s) Guardian Name _____ Phone _____ SS# _____
Address if different then above. _____

Patient Signature
YOU MUST ACKNOWLEDGE ALL BELOW TO BE SEEN IN THE OFFICE

I request that payment of authorized INSURANCE/MEDICARE/MEDIGAP benefits to be made on my behalf to Ophthalmic Associates for any services furnished me by that physician or supplier. I authorized any holder of medical information about me to release to the CMS and its agents any information needed to determine these benefits payable for related services.
Patient/Parent/Guardian Signature _____ Date _____

I understand that my insurance will not cover all procedures including 92015 (refraction). In the event of a denial, I agree to pay for the procedure in its entirety. This statement is made and signed in accordance with section S1962 (a) (1) of the Omnibus Budget Reconciliation Act (COBRA) of 1986.
Patient/Parent/Guardian Signature _____ Date _____

In consideration of the services rendered, I the undersigned hereby agree to pay Ophthalmic Associates in accordance with the regular fees and terms of the office.
I also understand that providing insurance information does not relieve me of the responsibility of any claim. If I have an HMO or PPO, I must follow the rules and regulations of my insurance company.
I understand that it is my responsibility to resolve any disputes with my insurance company for non-payment after Ophthalmic Associates has submitted the bill.
Patient/Parent/Guardian Signature _____ Date _____
Office Staff Signature/Initials_____ **Date** _____ **rev 8/2023 ve**

PLEASE USE BLACK PEN

Health Survey

Name: _____ DOB: _____

Medical History

Are you **ALLERGIC** to any **medications**? Yes / No If yes, please list: _____

_____

What medications you are you taking? (Provide list, if applicable) _____

_____

_____

_____

Systemic History			**Eye History**	
Height:	Weight:		Glaucoma	YES / NO
Diabetes: ☐ Insulin ☐ non-insulin **If yes**, date diagnosed:		YES / NO	Cataract	YES / NO
			AMD (Age related macular degeneration)	YES / NO
High Blood Pressure		YES / NO	Retinal Disease	YES / NO
Stroke: **If yes**, date:		YES / NO	Diabetic Eye Disease	YES / NO
			Laser Treatment (retina/glaucoma)	YES / NO
Heart Attack: **If yes**, date:		YES / NO	Laser Vision Correction	YES / NO
			PRK (Photorefractive Keratectomy)	YES / NO
Heart Disease		YES / NO	RK (Radial Keratotomy)	YES / NO
Asthma		YES / NO	Any Other Eye Surgery **If yes,** Type:	YES / NO
COPD		YES / NO		
Emphysema		YES / NO	Any Eye Injury: **If yes,** Type:	YES / NO
Arthritis If yes, type:		YES / NO		
			Do you wear Glasses? **If yes,** how old are they?	YES / NO
Lupus: If yes, date diagnosed:		YES / NO		
			Do you wear Contact Lenses? ***If yes,*** *Please Bring info with you*	YES / NO
Thyroid Disease: **if yes**, Hypo/ Hyper		YES / NO	**Other: Usually, Male only**	
Cancer: **if yes,** type:		YES / NO	Have you ever taken Prostate Medication? i.e Flomax, Tamsulosin **If yes,** how long?	YES / NO
High Cholesterol		YES / NO		
Other conditions not listed above:				
Previous Surgery (s):				

Social History		
Smoke	YES / NO	If yes, how much?
Alcoholic Beverages	YES / NO	If yes, how much?
Exercise	YES / NO	If yes, how much?
Drive	YES / NO	If NO, why did you stop?
Family History		
Arthritis	YES / NO	If yes, relationship
Asthma	YES / NO	If yes, relationship
Cancer	YES / NO	If yes, relationship
Diabetes	YES / NO	If yes, relationship
Glaucoma	YES / NO	If yes, relationship
Heart Disease	YES / NO	If yes, relationship

Dr. Christopher R. Bruno
Ophthalmic Associates-The Eye Center
2835 South Delsea Drive Vineland, New Jersey 08360
Tel. 856-696-0020 Fax. 856-205-1721

Patient Request for Transmission of Protected Health Information to Alternate Address or by Alternate Means

Patient Name: _____DOB: _____

I understand that *Ophthalmic Associates* may release my PHI to a family member, friend, or other person I indicate is involved in my care unless I object. *Ophthalmic Associates* may disclose my PHI to the following persons acting on my behalf:

1. *Name:* _____
   Relationship: _____*Phone Number:* _____
2. *Name:* _____
   Relationship: _____*Phone Number:* _____
3. *Name:* _____
   Relationship: _____*Phone Number:* _____

I understand that I can request that *Ophthalmic Associates* send information to me at an alternate address. Please send information to me at the following address and/or by the following means.

Address: _____unit/apt_____
City_____ State: _____ Zip: _____

Ophthalmic Associates will agree to this request so long as the information can easily be provided in the manner requested. I understand that if *Ophthalmic Associates* will incur costs by complying with the request, I will be required to provide payment to *Ophthalmic Associates* in advance.

☐ ***Acknowledge Receipt of Notice of Privacy Practice*** ☐ ***Decline Notice of Privacy Practice***

*****May we leave **test results** on your answering machine? YES_____ NO _____
If no would you like your **results** mailed to you? YES_____ NO _____

What is the best number to reach you at: _____

PLEASE NOTE CONFIRMATION CALLS REGARDING APPOINTMENTS MAY BE LEFT ON A MACHINE

_____ _____
Signature of Patient or Patient's Authorized Representative Date

_____
Representative's Name and Authority:

Patient Name: _____ DOB: _____

Office Billing/Insurance Information

Due to changes in the Healthcare environment and regulations of your insurance company, with which we must comply, we now have a new billing/insurance policy.

CO-PAYMENTS: If a co-payment is required with your insurance coverage, it will be collected at the time of the visit. Please be sure to bring this with you for your scheduled appointment.

REFERRALS: If your insurance coverage requires a referral to see a specialist, IT IS YOUR RESPONSIBILITY to bring the referral with you on the date of service. Please contact your primary care physician to obtain this referral. If you do not bring the referral with you, you will be responsible for full payment for that visit or you will NOT be allowed to receive treatment. We will be happy to reschedule your appointment for another day. Your insurance carrier sets these rules.

BILLING: If a balance remains on your account, because of a deductible or any insurance issue not resolved, you will be responsible for payment of that balance prior to being seen again.

We want your association with our office to be a pleasant one. We are available to address any concerns and assist in any matter.

I have read the above policy and accept my financial obligation to Ophthalmic Associates, PA. My signature represents my acceptance.

Patient Signature: _____ Date: _____

Patient Portal Consent

Our office is beginning to go electronic with most of our records and part of this process requires us to collect an e-mail address from our patients. In order to meet the criteria, patients will have to register into the portal by creating a password and user name.

A patient portal is a secure online website that gives patients convenient 24-hour access to personal health information. Using a secure username and password, patients can view health information such as: Discharge summaries, Medications, Recent doctor visits, Request prescription refills, Update contact information, Schedule non-urgent appointments

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) permits the disclosure of health information about the patient without requiring the patient's express consent.

E-Mail Address: _____ ☐ I do not wish to provide an e-mail address

Patient Signature: _____ Date: _____