RONALD SACHS, M.D.
RETINA ASSOCIATES OF
NORTHWEST NEW JERSEY, P.A.

MEDICAL AND SURGICAL DISEASES
OF THE RETINA, VITREOUS AND MACULA
DIABETIC RETINOPATHY

8 SADDLE RD., STE. 201
CEDAR KNOLLS, NJ 07927
(973) 539-3600

Mr. Mrs. Ms. _____
has an appointment on

☐ Mon. ☐ Tues. ☐ Weds. ☐ Thurs. ☐ Fri.

Date: _____ at _____ am pm

Thank you for choosing Ronald Sachs, MD of Retinal Associates of Northwest NJ. Please complete our questionnaire and bring it with you on your scheduled appointment.

Your exam requires the dilation of both eyes. You should wear sunglasses for the remainder of the day. You should not drive or operate machinery and should exercise care in your daily activities.

It is very important that you bring your **insurance cards** with you as well as any insurance **referral forms, authorization numbers**, or other insurance information.

Ronald Sachs, MD/Retina Associates of Northwest NJ
8 Saddle Rd., Ste. 201, Cedar Knolls, NJ 07927
(973) 539-3600

Directions:

- **FROM THE SOUTH:** on Route **287 NORTHBOUND** to **Exit 36B** (Lafayette Ave.). Bear around to the right and get into far right lane. At the traffic light (Mercedes dealer on far corner), turn right on **Ridgedale Ave.** At the 3rd traffic light turn left on **Hanover Ave.** At the 1st traffic light turn right onto **Horse Hill Rd.** Turn left at the 1st street on **Saddle Rd. The Hanover Medical Arts building is #8 on the right side.**

- **FROM THE NORTH:** on Route **287 SOUTHBOUND** to **Exit 36** (Morris-Lafayette-Ridgedale exit) stay in the right lane. At the traffic light turn right onto **Ridgedale Ave.** At the 2nd traffic light turn left onto **Hanover Ave.** At the 1st traffic light turn right onto **Horse Hill Rd.** Turn left at the 1st street onto **Saddle Rd. The Hanover Medical Arts Building is #8 on the right side.**

- From Southern Essex and Union County: Route 78 to Route 24 to Route 287 South.
- From Northern Essex County: Route 280 to Route 287 South.
- From Sussex and Passaic Counties: Route 80 to Route 287 South.
- From Warren, Hunterdon and Somerset Counties: Route 78 and 287 North.

Free Parking Available

New Patient Information

Date: _____

Welcome to our office. Please **complete** all four pages of this packet and return it to the receptionist, who will use the information to prepare your chart.

PLEASE PRINT

Patient's Name: _____ Age ___ Sex ___ Birthdate: _____ Patient's SSN #: _____

Street Address _____

City _____ State _____ Zip Code _____

Telephone (Daytime): (___) _____ Telephone (Evening): (___) _____

Cell Phone: (___) _____ Emergency Number: (___) _____

Insured's Occupation: _____ Employer: _____

Employer's Address & Phone: _____

Name of Spouse/Parent: _____ Employer: _____

Spouse/Parent's Employer's Address & Phone: _____

Please fill in **first & last names, address** and **phone number** of your **eye** doctor and **medical** doctor:

	Eye Doctor	**Medical Doctor**	**Pharmacy**
Name:			
Address:			
Phone #			

Name of **PRIMARY** Insurance Carrier: _____

Policyholder's Name: _____ Policyholder's Birthdate: _____ Policyholder's SSN: _____

Name of **SECONDARY** Insurance Carrier: _____

Policyholder's Name: _____ Policyholder's Birthdate: _____ Policyholder's SSN: _____

Whom should we notify in case of emergency? (nearest relative (**other than spouse**) / friend)

Name: _____ Relationship: _____

Address: _____

Home Phone: (___) _____ Work Phone: (___) _____

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I acknowledge that I have received the "Notice of Privacy Policies & Practices".

Authorization to release information:

I hereby authorize the above doctor/doctors to furnish the insured's insurance company all information which said insurance company may request concerning my present claim.

Assignment of Insurance benefits:

I hereby assign to the doctor all money to which I am entitled for expense relative to the services performed from time to time, but not to exceed my indebtedness to said doctor. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor for charges.

_____ _____ _____

Responsible Party's Signature | Patient's Signature | 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):

_____

_____

Do you have **allergies** to any medications? ☐ YES ☐ NO

If YES, list the medications:

_____

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

_____

_____

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy):

_____

_____

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			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous 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			
Fever			
Weight loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			

CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
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: _____

Education (high school, vocational school, college degree): _____

Marital Status (married, divorced, single, widowed): _____

Living Arrangements: _____

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 tried to wear contact lenses? ☐ YES ☐ NO

Do you currently wear contact lenses? ☐ YES ☐ NO

If YES, how long have you worn 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: occasional 1 per day 2-3/day 4+/day

Do you smoke? ☐ YES ☐ NO If YES: occasional 1/2 pack/day 1 pack/day 1+ pack/day

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

History reviewed. ☐ No Changes. ☐ Additions as noted above.