

COSTELLO EYE CARE
53 KENT ROAD HOWELL, NJ 07731
732-534-5622

DR. JAMIE COSTELLO DR. JOHN COSTELLO

Welcome to Costello Eye Care. Thank you for choosing us for your eye care needs. Please complete the following information.
Please print clearly – Thank You!

Date: _____

PATIENT INFORMATION

Last Name First MI

Street Address

City ST A T E Zip

Occupation: _____

DOB: _____ Age: _____ M/F

PHONE: _____
Home Cell

SS #: _____ Marital status: S/M/D/W

Email: _____
(For appointment reminders, sunglass or contact lens sales only)

If minor, parent name: _____ FT student: Y / N

EMERGENCY CONTACT: _____
Name Phone

RELATIONSHIP: _____

PRIMARY CARE PHYSICIAN: _____

HOW WERE YOU REFERRED TO OUR OFFICE?
___ Web Search ___ ADVERTISEMENT DR: _____

Another patient: _____ or _____ INSURANCE LISTING

VISION INSURANCE

INSURANCE COMPANY: _____

INSURANCE ID#: _____

GROUP #: _____

NAME OF INSURED: _____

Relationship to Insured Self Spouse Child Other

INSURED'S DOB: _____

INSURED'S ADDRESS: _____

INSURED'S PHONE: _____ EMPLOYER: _____

PRIMARY MEDICAL INSURANCE INFORMATION

INSURANCE COMPANY: _____

INSURANCE ID#: _____

GROUP #: _____

NAME OF INSURED: _____

Relationship to Insured Self Spouse Child Other

INSURED'S DOB: _____

INSURED'S ADDRESS: _____

INSURED'S PHONE: _____ EMPLOYER: _____

SECONDARY MEDICAL INSURANCE INFORMATION

INSURANCE COMPANY: _____

INSURANCE ID#: _____

NAME OF INSURED: _____

Relationship to Insured Self Spouse Child Other

INSURED'S DOB: _____

INSURED'S ADDRESS: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I, (or my dependent) have the insurance coverage listed above and assign directly to Costello Eye Care all Medicare or other insurance benefits payable for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the Doctor to release any information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient (or parent if minor): _____ Date: _____

COSTELLO EYE CARE

PATIENT HISTORY QUESTIONNAIRE

Patient Name: _____ DOB: _____

Today's Date: _____

PLEASE ANSWER **YES OR NO** FOR EACH QUESTION

Primary reason for today's visit:

- YES NO Yearly health exam
- YES NO Eye Infection/Problem
- YES NO LASIK/PRK evaluation
- YES NO Remove foreign body from eye

OCULAR/EYE INFORMATION

Do you presently have any problems with the following?

- YES NO Blurred vision at distance
- YES NO Blurred vision at near
- YES NO Eye strain w/computer use
- YES NO Itching/burning/discharge
- YES NO Red eyes
- YES NO Gritty feeling/dryness
- YES NO Watery eyes
- YES NO Eye pain
- YES NO Double Vision
- YES NO Glare/Light sensitivity/halos
- YES NO Floaters
- YES NO Flashes of light
- YES NO Problems with night vision/driving
- YES NO Do you currently wear glasses?
Full Time Part Time Distance Close

YES NO Do you currently wear contact lenses?
Brand _____

Have you ever had any of the following? Explain

- YES NO Eye infection _____
- YES NO Eye injury/surgery _____

Have you ever been told you have any of the following?

- YES NO Glaucoma
- YES NO High pressure in your eyes
- YES NO Cataracts
- YES NO Macular Degeneration
- YES NO Retinal holes/tears/degeneration
- YES NO Keratoconus

Any other problem not listed: _____

Do you?

- YES NO Smoke _____/day
- YES NO Drink alcohol _____/day
- YES NO If female, are you pregnant or nursing?
- YES NO Are you allergic to any medication(s)

If yes, list name of medication

YES NO Do you suffer from seasonal or environmental allergies?

MEDICAL INFORMATION

Do you have any of the following?

- YES NO High Blood Pressure
- YES NO Heart Disease
- YES NO Diabetes (Type I/Type II)
- YES NO High Cholesterol
- YES NO Asthma
- YES NO Migraines/Headaches
- YES NO Arthritis
- YES NO MS
- YES NO Lupus
- YES NO HIV
- YES NO Cancer

Other (please describe): _____

Do you have problems with any of these systems?

- YES NO Nervous
- YES NO Mental
- YES NO Respiratory (lungs/breathing)
- YES NO Musculoskeletal (muscles/joints)
- YES NO Gastrointestinal (stomach/intestines)
- YES NO Genitourinary (genitals/kidney/bladder)
- YES NO Endocrine (hormones/glands/thyroid)
- YES NO Hematologic (blood/lymph)
- YES NO Integument (skin)
- YES NO Ears/Nose/Throat
- YES NO Cardiovascular (heart/blood vessels)

CURRENT MEDICATIONS:

SURGERIES:

Does anyone in your family have any of the following conditions?

- YES NO High Blood Pressure
- YES NO Heart Disease
- YES NO Diabetes
- YES NO Cancer
- YES NO Glaucoma
- YES NO Cataracts
- YES NO Macular Degeneration
- YES NO Retinal problems
- YES NO Blindness

Other: _____

Date of last eye exam: _____ Dr: _____

Date of last dilation: _____

An eye exam might include dilation of the pupils. This routine procedure consists of using drops to dilate the pupils (make them temporarily larger). This allows us to evaluate the retina more completely. Glaucoma, retinal holes or tears, and certain degenerations can have no symptoms. If not detected, these problems can be vision threatening. The effects of the drops last a few hours after installation. You will be sensitive to bright lights, and blurred, especially for near vision. Please initial: ____ I elect to have this test performed ____ I elect NOT TO HAVE DILATION DONE TODAY, AND RELEASE DR & STAFF FROM ANY LIABILITY AS A RESULT

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I, _____ (Patients name), acknowledge that I have received the Notice of Privacy Practices of Costello Eye Care.
 Signature of Patient (or personal representative) _____ Date: _____