Registration :

John S Greco Jr, MD, PA

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Address	Home:	How did you hear of us?
	Work:	
Address 2	Cell:	
	Email:	

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Pharmacy Phone

Physician **Family Physician** **Referring Physician**

Medical Insurance	Name & Address	Policyholder	Relationship	Policy ID	Group ID
1					
2					
3					

Guarantor (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

HIPAA Approved Contacts

1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

2. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to John S Greco Jr, MD, PA , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date	
X		**John S Greco Jr, MD, PA** PO BOX 7400 Shrewsbury, NJ 07702

Phone: 732-741-7997
Email:

Please attach all pertinent insurance ID cards for photocopying.

PATIENT MEDICAL INFORMATION

Name _____ Age _____

MEDICAL INFORMATION

Please Describe Your Symptoms:

_____

_____

Previous Eye Disease or Eye Surgery:

_____

Present Medications:

_____

_____

Drug Allergies:

_____

MEDICAL HISTORY

	YES	NO	FAMILY		YES	NO	FAMILY
Heart Disease	____	____	____	Asthma	____	____	____
Diabetes	____	____	____	Hepatitis	____	____	____
Hypertension	____	____	____	Ulcers	____	____	____
Kidney Problems	____	____	____	Seizures	____	____	____
Thyroid	____	____	____	Cancer	____	____	____
Lung Problems	____	____	____	HIV Or AIDS	____	____	____
Joint Problems	____	____	____	Mental Illness	____	____	____

SURGERIES (PLEASE INCLUDE YEAR):

_____

SOCIAL HISTORY:

	YES	NO
Smoking	____	____
Alcohol Use	____	____
Drug Abuse	____	____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

PLEASE SIGN: _____ **DATE:** _____

REFRACTION

PATIENT NAME _____ CHART # _____

NOTE: YOU NEED TO MAKE A CHOICE ABOUT RECEIVING THIS HEALTHCARE SERVICE.

YOUR INSURANCE DOES NOT PAY FOR ALL YOUR HEALTHCARE COST. YOUR INSURANCE COMPANY ONLY PAYS FOR COVERED ITEMS AND SERVICES WHEN INSURANCE COMPANY'S RULES ARE MET. THE FACT THAT YOUR INSURANCE COMPANY DOES NOT PAY FOR A PARTICULAR ITEM OR SERVICE, DOES NOT MEAN THAT YOU SHOULD NOT RECEIVE IT. THERE MAY BE A GOOD REASON YOUR DOCTOR RECOMMENDED IT.

SERVICE OF REFRACTION: REFRACTION IS AN EXAM TO CHECK THE EYEGLASS PRESCRIPTION IN ORDER TO HAVE A CURRENT PRESCRIPTION ON FILE WHETHER OR NOT THE PRESCRIPTION HAS CHANGED.

THE PURPOSE OF THIS FORM IS TO HELP YOU MAKE AN INFORMED CHOICE ABOUT WHETHER OR NOT YOU WANT TO RECEIVE THIS SERVICE, KNOWING YOUR INSURANCE MAY NOT COVER IT. **THE COST OF THE REFRACTION IS $75.00.**

_____ **YES I WANT TO RECEIVE THESE SERVICES**

I UNDERSTAND MY INSURANCE MAY NOT COVER THE REFRACTION. I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR THE PAYMENT. THAT IS, I WILL PAY OUT OF POCKET.

_____ **NO I DO NOT WANT TO RECEIVE THESE SERVICES**

I WILL NOT RECEIVE THESE SERVICES; THEREFORE I UNDERSTAND I WILL NOT RECEIVE A PRESCRIPTION FOR GLASSES AT THE END OF MY EXAMINATION.

SIGNATURE _____

DATE _____

Refills of Medications

We will not refill prescriptions late in the evening or on weekends. Please do not wait until you are almost out of drops or pills before contacting us. If in doubt about a refill, please contact your pharmacist and they will tell you if you have any left on your prescription.

Telephone Calls

Routine calls and matters can only be handled during normal office hours (Mon, and Thurs 9-7, Tues and Wed 9-5, Fri 9-3). The person answering the telephone will take your message, attach it to your chart and put it on the doctor's desk. The doctor or his staff will then return all routine calls as the schedule permits. If for some reason the call is not returned that day, please call us the next morning and we will again bring it to the doctor's attention. Please note that sometimes when the doctor returns a call, he either gets a busy signal or no answer. There are no walk-in appointments - call ahead if it is an emergency and we will fit you in as soon as possible.

Referral Forms for Managed Care

It is the patient's responsibility to bring in a referral form if they are insured under a managed care program. **We try very hard to remind patients to bring in the referral forms, but please remember this is your insurance and ultimately your responsibility. If services are denied by your insurance company due to the absence of a referral, you will be responsible for payment of such services.** If you are not sure if you have a current referral form, please contact our office and we will be happy to check it for you.

Missed or Cancelled Appointments

If you need to cancel your appointment, we kindly ask that you give 24 hours notice so that we can have time to schedule another patient. Otherwise, your account may be charged. Thank you.

I acknowledge that I have read the above information.

_____ _____

Patient's Signature Date

www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

HIPAA PRIVACY FORM

PATIENT NAME _____

SIGNATURE _____

DATE _____