STEPHEN J. GORDON, M.D.

OPHTHALMOLOGY SURGICAL ASSOCIATES

317 Cleveland Ave, 2nd Fl.
Highland Park, N.J. 08904

579A, suite 101, Cranbury Rd.
East Brunswick, N.J. 08816

Ph: 732-545-0362
Fax: 732-545-7499
Website: gordoneyes.com

Patient Registration Form

PATIENT INFORMATION

LAST NAME | FIRST NAME | MIDDLE INITIAL

STREET ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE | BUSINESS PHONE | CELL PHONE

EMPLOYER | EMPLOYER LOCATION | EMPLOYMENT STATUS ◯ Full Time ◯ Part Time ◯ Retired

BIRTH DATE | AGE | GENDER ◯ Male ◯ Female | SOCIAL SECURITY NO.

REASON FOR VISIT

SEND BILL TO: (if different address) | MARITAL STATUS

COLLEGE STUDENT STATUS ◯ Full Time ◯ Part Time

PHARMACY | PHONE

EMERGENCY CONTACT | PHONE

PRIMARY INSURANCE INFORMATION

LAST NAME | FIRST NAME | MIDDLE INITIAL

STREET ADDRESS (if different) | CITY | STATE | ZIP CODE

BIRTH DATE OF INSURED | SOCIAL SECURITY NO. | RELATIONSHIP ◯ Self ◯ Spouse ◯ Child

INSURANCE CO. | INSURANCE PHONE

FULL INSURANCE CO. ADDRESS

INSURED'S ID | EFFECTIVE DATE OF POLICY | GROUP NUMBER | CO PAYMENT

SECONDARY INSURANCE INFORMATION

LAST NAME | FIRST NAME | MIDDLE INITIAL

BIRTH DATE | SOCIAL SECURITY NO. | INSURANCE PHONE

INSURANCE CO.

FULL INSURANCE CO. ADDRESS

INSURED'S ID | EFFECTIVE DATE OF POLICY | GROUP NUMBER

I hereby assign the policy rights and benefits to the Doctor and authorize direct payment from my Insurance Company for professional services rendered. I understand that failing to provide proper insurance information at the time of my visit may result in my being responsible for the entire charge.

I further authorize the Doctor to release any information concerning my examination or treatment to my insurance company. I agree to be personally responsible for any unpaid balance, deductible or co-payment, and if I receive any payments from my insurance company in error, I will sign them directly over the the Doctor.

Patient Signature ______________________

Date ______________________

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Name: ______________________ **Date:** ______________

Eye Complaint: ______________________________________

____

____

____

Please circle any eye you have had:

CATARACTS GLAUCOMA CONTACTS FLOATERS CROSSED EYES RETINAL PROBLEMS

Eye Surgery: ______________________ **Date:** ______________

Medical Conditions: ______________________________________

____

____

____

Medications: ______________________________________

____

Allergies: ______________________________________

____

Primary Doctor's Name: ______________________ **Doctor's Phone:** ______________

STEPHEN J. GORDON, M.D.
OPHTHALMOLOGY SURGICAL ASSOCIATES

Ophthalmology Section Chief
Dept. of Surgery
St. Peter's University Medical Ctr.

Founder and Medical Director
Somerset Eye Institute

Referral Policy

I understand that the policies and rules of health plans vary greatly and that Dr. Gordon and his staff have made every effort to be fair in determining whether I need a referral for my office visit.

I also understand that Dr. Gordon and his staff cannot expend the time required to phone my plan and wait on hold to find out what is my health plan's policy regarding referrals.

I understand that because I am ultimately responsible to know the features of my plan, that I will be financially responsible should my plan deny any payment to Dr. Gordon for my ocular evaluation.

____

Patient Signature

____

Date

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Acknowledgement of Receipt of Notice of Privacy Practices

I, ____________________________ , acknowledge and agree that I have received a copy of Stephen J. Gordon M.D., P.A.'s Notice of Privacy Practices.

Patient Signature	**Date**
Patient Legal Representative (if applicable)	**Date**
Print Name of Legal Representative	**Relationship to Patient**

FOR CLINIC USE ONLY:

Stephen J. Gordon, M.D., P.A. made the following good faith efforst to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices.

Identify the efforst that were made to obtain the individual's written acknowledgement, including reasons (if known) why the written acknowledgement was not obtained.

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