Retina Consultants, PA II

PATIENT REGISTRATION INFORMATION

Date: _____ SS#:_____ Date of Birth: _____ Age: _____

Last Name: _____ First Name: _____ Middle Initial: ____ Gender: · Male · Female

Address: _____Apt#:_____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone: _____

Email: _____

Marital Status (circle one): Single/Married/Div./Sep./Widowed Spouse's Name (if applicable): _____

Mother's First Name: _____ Father's First Name: _____

Employer: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Pharmacy Address: _____ Phone: _____

Referred by: _____

In case of emergency, who should we contact? _____ Phone: _____

☐ Workman's Compensation: _____ ☐ No Fault: _____

PRIMARY INSURANCE:

Person responsible for account: _____ Phone: _____

Relationship to Patient: _____ Date of Birth: _____

Address (if different from patient): _____

Ins. Company: _____Ins. Company Address: _____

Subscriber ID#: _____ Group #: _____Co-pay: $_____

ADDITIONAL INSURANCE:

Person responsible for account: _____ Phone: _____

Relationship to Patient: _____ Date of Birth: _____

Address (if different from patient): _____

Ins. Company: _____Ins. Company Address: _____

Subscriber ID#: _____ Group #: _____Co-pay: $_____

Signature of Responsible Party: _____ Date:_____

MEDICAL INFORMATION SHEET **NAME:** _____

Chief Complaint: What is the main or primary problem with your eye(s), and when did you first notice symptoms or were you told of diagnosis?

_____

_____

_____

_____

Past History: Do you have or have you had any of the following problems or conditions? Please answer **ALL** questions - Indicate **YES** or **NO**. If the answer is **YES**, provide a brief explanation.

EYES			**EXPLANATION**
Glaucoma	**YES**	**NO**	_____
Cataract	**YES**	**NO**	_____
Lazy Eye (Amblyopia)	**YES**	**NO**	_____
Crossed Eyes (Strabismus)	**YES**	**NO**	_____
Macular Degeneration	**YES**	**NO**	_____
Retinal Detachment	**YES**	**NO**	_____
Eye Injury	**YES**	**NO**	_____
Eye Inflammation	**YES**	**NO**	_____
Laser Surgery	**YES**	**NO**	_____
Operative Surgery	**YES**	**NO**	_____
GENERAL HEALTH			
Fevers	**YES**	**NO**	_____
Weight Loss	**YES**	**NO**	_____
Fatigue	**YES**	**NO**	_____
Sinusitis / Nasal Allergies	**YES**	**NO**	_____
Hearing Loss	**YES**	**NO**	_____
Dry Mouth	**YES**	**NO**	_____
Angina / Chest Pain	**YES**	**NO**	_____
Heart Attack	**YES**	**NO**	_____
Congestive Heart Disease	**YES**	**NO**	_____
Rheumatic Heart Disease	**YES**	**NO**	_____
Heart Murmur	**YES**	**NO**	_____
Irregular or Slow Heartbeat	**YES**	**NO**	_____
High Blood Pressure	**YES**	**NO**	_____
Stroke	**YES**	**NO**	_____
Shortness of Breath	**YES**	**NO**	_____
Asthma	**YES**	**NO**	_____
Bronchitis	**YES**	**NO**	_____
Emphysema	**YES**	**NO**	_____
Heartburn / Ulcer	**YES**	**NO**	_____
Hepatitis	**YES**	**NO**	_____
Liver Disease	**YES**	**NO**	_____
Kidney Disease	**YES**	**NO**	_____
Kidney Stones	**YES**	**NO**	_____

Past History: Do you have or have you had any of the following problems or conditions? Please answer **ALL** questions - Indicate **YES** or **NO**. If the answer is **YES**, provide a brief explanation.

General Health (cont)			**EXPLANATION**
Eczema / Rash	**YES**	**NO**	_____
Skin Cancer / Moles Removed	**YES**	**NO**	_____
Mouth Ulcers	**YES**	**NO**	_____
Arthritis	**YES**	**NO**	_____
Rheumatologic Condition (ie:Lupus)	**YES**	**NO**	_____
Arm or Leg Weakness or Numbness	**YES**	**NO**	_____
Multiple Sclerosis	**YES**	**NO**	_____
Psychiatric Condition	**YES**	**NO**	_____
Depression	**YES**	**NO**	_____
Anxiety	**YES**	**NO**	_____
Anemia	**YES**	**NO**	_____
Sickle Cell Disease	**YES**	**NO**	_____
Easy Bruising / Bleeding	**YES**	**NO**	_____
Blood Clotting Disorder	**YES**	**NO**	_____
Diabetes	**YES**	**NO**	_____
Thyroid Condition	**YES**	**NO**	_____
Cancer	**YES**	**NO**	_____
Are you or could you be pregnant?	**YES**	**NO**	_____
Do you drink? How much?	**YES**	**NO**	_____
Do you smoke? How much?	**YES**	**NO**	_____
Do you drive?	**YES**	**NO**	_____
Are you allergic to any medications / dyes?	**YES**	**NO**	_____
Do you take any medications (including drops)? If, possible indicate dosages.	**YES**	**NO**	_____
Have you had any previous surgery?	**YES**	**NO**	_____
Type? When?			_____
Should we be aware of any other matter Regarding your overall health?	**YES**	**NO**	_____

Patient Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____

RETINA CONSULTANTS, PA II

AUTHORIZATION OF BENEFITS

Name of Beneficiary: _____

Health Insurance Claim #: _____

I request that payment of authorized health insurance benefits, including Medicare and Medigap, be made either to me or on my behalf to Dr._____ for services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits payable for related services.

Signature of Responsible Party: _____ Date: _____

Commercial Insurance

I hereby authorize direct payment of surgical/medical benefits to Dr._____ for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance, including co-pays, deductibles, refractions, and differences between surgeon's charges and allowable. I hereby authorize Dr._____ to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

Signature of Responsible Party: _____ Date: _____

RETINA CONSULTANTS, PA II

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

DATE: _____

I acknowledge that I was provided with a copy of the RETINA CONSULTANTS, PA II Notice of Privacy Practices.

_____ _____

Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

_____ _____

Personal Representative (Print) Personal Representative's Signature

_____

Relationship

For RETINA CONSULTANTS, PA II use only.

Complete this section if this form is not signed and dated by the patient or patient's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Retina Consultants, PA II, Notice of Privacy Practices but was unable to for the following reason:

□ Patient refused to sign

□ Patient unable to sign

□ Other _____

_____ _____

Employee Name Date

This form should be placed in the patient's medical record