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): _____

Employer: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Referred by: _____

Pharmacy Name/Address: _____

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

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

*****Are you currently residing in a Skilled Nursing Facility or Rehabilitation Center? If yes, please list name and phone******

Facility_____Phone: _____

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**	
Ocular Surgery	**YES**	**NO**	
GENERAL HEALTH (Please circle)			
Diabetes (Type 1 or Type 2)	**YES**	**NO**	**Diagnosis Date :**
Kidney Disease/ Dialysis	**YES**	**NO**	
Thyroid Disorder/ Autoimmune Ds.	**YES**	**NO**	
Bleeding Disorder or Anemia	**YES**	**NO**	
Rheumatologic Condition(ie:Lupus)	**YES**	**NO**	
Heart Disease	**YES**	**NO**	
A-Fib/Defibrillator/Pacemaker	**YES**	**NO**	
Heart Attack	**YES**	**NO**	
High Blood Pressure	**YES**	**NO**	
High Cholesterol	**YES**	**NO**	
Migraine/Dizziness	**YES**	**NO**	
Stroke or Neurological Disorder	**YES**	**NO**	
Multiple Sclerosis	**YES**	**NO**	
Seizures or Convulsions/ Tremors	**YES**	**NO**	
Cancer/ Radiation/Chemotherapy	**YES**	**NO**	
Sleep Apnea	**YES**	**NO**	
Asthma/Bronchitis/Emphysema	**YES**	**NO**	
Sinusitis/ Nasal Allergies	**YES**	**NO**	
AIDS/HIV or other Infectious Ds. (i.e:Hepatitis)	**YES**	**NO**	
Liver Disease	**YES**	**NO**	
Arthritis/Osteoporosis/Joint Pain	**YES**	**NO**	
Anxiety/ Depression/Psychiatric Ds.	**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**
Fevers/Weight Loss/Fatigue	**YES**	**NO**	
Hearing Loss	**YES**	**NO**	
Dry Mouth	**YES**	**NO**	
Heartburn / Ulcer	**YES**	**NO**	
Arm or Leg Weakness or Numbness	**YES**	**NO**	

SOCIAL HISTORY

Do you drive?	**YES**	**NO**	
Do you smoke? If so, how often?	**YES**	**NO**	
Is there current or history of substance abuse?	**YES**	**NO**	
Living Conditions (ie: Alone,with Family,Facility)	**YES**	**NO**	
Rehabilitation Center/Nursing Home			
Are you or could you be pregnant?	**YES**	**NO**	
Are you allergic to any medications/ latex/dyes?	**YES**	**NO**	
Have you had previous surgery?	**YES**	**NO**	
Type? When?			
Are you taking medications?	**YES**	**NO**	
Please include dosage and frequency			

PLEASE LIST ALL DOCTORS YOU ARE CURRENTLY SEEING:

	Name	**Phone**
Ophthalmologist		
Primary Care Physician		
Cardiologist		
Endocrinologist		
Neurologist		
Nephrologist		

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