WELCOME TO RETINA CONSULTANTS

PATIENT INFORMATION:

Today's Date ____________

Last Name ______________________ Middle Name ______________________

First Name ______________________ Preferred Name ______________________

Date of Birth ____________ Marital Status ____________ Social Security Number ____________

Sex ____________ Gender Identity ____________ Sexual Orientation ____________ Race ____________

Ethnicity ______________________ Preferred Language ______________________

Home Address ____

E-Mail Address ____

Home Tel. (______) ____________ Cell Tel. (______) ____________ Work Tel. (______) ____________ Ext. ______

Preferred Method of Telephone Contact: ❑ Home ❑ Cell ❑ Work

Employment Status ____________ Employer's Name ______________________

Address ____

Referring Doctor's Name ______________________ City ____________

Primary Care Physician's Name ______________________ City ____________

Other Specialist 1 ______________________ City ____________ Specialty ____________

Other Specialist 2 ______________________ City ____________ Specialty ____________

Preferred Pharmacy ______________________ City ____________

Insurance Company Name 1 ______________________ I.D. # ____________

Insurance Company Name 2 ______________________ I.D. # ____________

Insurance Company Name 3 ______________________ I.D. # ____________

Emergency Contact's Name ______________________ Tel. (______) ____________ Relation ____________

For Minor Patients:

Mother's Name ______________________ Tel. (______) ____________

Father's Name ______________________ Tel. (______) ____________

I, the undersigned, assign to Retina Consultants, PC, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all 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.

X ______________________ **X** ____________ **X** ______________________ **X** ____________

Signature of patient *(Parent or Guardian if Minor)* **Date** **Reviewed by** **Date**

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits (if applicable) be made to Marion J. Stoj MD, Jerry Neuwirth MD, Peter H. Judson MD, Michael S. Ruddat MD, Andrew J. Packer MD, Ron Margolis MD, and/or Scott D. Walter MD for any services provided to me. I authorize any holder of medical information about me to release to the health care administration and its agents any information needed to determine these benefits or the benefits payable for related services.

X ______________________ **X** ____________ **X** ______________________ **X** ____________

Signature of patient *(Parent or Guardian if Minor)* **Date** **Reviewed by** **Date**

CLINICAL INFORMATION:

Do you currently have any problems in the following areas (if yes, provide information):

Head:

Y N N/A

❑ ❑ ❑ Headaches . . . . if yes, explain ______

❑ ❑ ❑ Migraines . . . . if yes, explain ______

Eyes:

Y N N/A

❑ ❑ ❑ Loss of vision . . . . if yes, explain ______

❑ ❑ ❑ Blurred vision . . . . if yes, explain ______

❑ ❑ ❑ Distorted vision / halos. . . . . if yes, explain ______

❑ ❑ ❑ Double vision . . . . if yes, explain ______

❑ ❑ ❑ Dryness . . . . if yes, explain ______

❑ ❑ ❑ Mucous discharge . . . . if yes, explain ______

❑ ❑ ❑ Redness . . . . if yes, explain ______

❑ ❑ ❑ Itching / burning . . . . if yes, explain ______

❑ ❑ ❑ Foreign body sensation . . . . if yes, explain ______

❑ ❑ ❑ Excess tearing / watering. . . if yes, explain ______

❑ ❑ ❑ Glare / light sensitivity . . . . . if yes, explain ______

❑ ❑ ❑ Eye pain / soreness . . . . if yes, explain ______

❑ ❑ ❑ Infection of eye / lid . . . . if yes, explain ______

Do you currently have any problems in the following areas (if yes, provide information):

Y N N/A

❑ ❑ ❑ Do you have difficulty when driving? . . if yes, explain ______

❑ ❑ ❑ Do you have a problem with night vision? . . if yes, explain ______

❑ ❑ ❑ Do you currently wear contact lenses? . . if yes, explain ______

❑ ❑ ❑ Ears / nose / mouth / throat . . . . if yes, explain ______

❑ ❑ ❑ Respiratory (lungs / breathing) . . . . if yes, explain ______

❑ ❑ ❑ Cardiovascular (heart / blood vessels). . . if yes, explain ______

❑ ❑ ❑ Gastrointestinal (stomach / intestines) . . if yes, explain ______

❑ ❑ ❑ Genitourinary (genitals / kidneys / bladder) . . if yes, explain ______

❑ ❑ ❑ Bones / joints / muscles . . . . if yes, explain ______

❑ ❑ ❑ Neurological system. . . . . if yes, explain ______

❑ ❑ ❑ Lymphatics (lymph nodes / swelling) . . if yes, explain ______

❑ ❑ ❑ Hematopoletic (blood) . . . . if yes, explain ______

❑ ❑ ❑ Allergic / immunologic . . . . if yes, explain ______

❑ ❑ ❑ Seasonal allergies. . . . . if yes, explain ______

❑ ❑ ❑ Hay fever symptoms . . . . if yes, explain ______

❑ ❑ ❑ Psychiatric . . . . if yes, explain ______

❑ ❑ ❑ Are you diabetic . . . . if yes, ❑ Type 1 ❑ Type 2 and since when ______

do you know your A1C level ______

CLINICAL INFORMATION CONTINUED:

Current height ______________________ **weight** ______________________

Do you currently have any problems in the following areas (if yes, provide information):

Y	N	N/A		
❏	❏	❏	Persistent cough (lasts more than 3 wks)	if yes, explain ______
❏	❏	❏	Bloody spetum	if yes, explain ______
❏	❏	❏	Night sweats	if yes, explain ______
❏	❏	❏	Weight loss	if yes, explain ______
❏	❏	❏	Fever	if yes, explain ______

List any medication you take, including over-the-counter medication and supplements:

Name	Dosage	Frequency

List any major illnesses and injuries you have sustained in the past:

____

List any eye disease / surgeries you have had in the past:

____

List any non-eye surgeries you have had in the past:

____

List all recent hospitalizations with explanations of what they were for:

____

Have you every had crossed eye, lazy eye, drooping eyelid, or prominent eyes? ❏ Yes ❏ No

Are you a previous contact lens wearer? ❏ Yes ❏ No

Do you have allergies to any medications? ❏ Yes ❏ No**; if so please list medication and reaction:**

Medication	Reaction

FAMILY HISTORY:

Has / does anyone in your family have any of the following:

Y N N/A

❑ ❑ ❑ Blindness . . . . if yes, relation to patient ____________________

❑ ❑ ❑ Cataract . . . . if yes, relation to patient ____________________

❑ ❑ ❑ Glaucoma . . . . if yes, relation to patient ____________________

❑ ❑ ❑ Macular degeneration . . . . . if yes, relation to patient ____________________

❑ ❑ ❑ Retinal detachment . . . . if yes, relation to patient ____________________

❑ ❑ ❑ Cancer . . . . if yes, relation to patient ____________________

❑ ❑ ❑ Diabetes . . . . if yes, relation to patient ____________________

❑ ❑ ❑ Heart attack(s) . . . . if yes, relation to patient ____________________

❑ ❑ ❑ High blood pressure . . . . if yes, relation to patient ____________________

❑ ❑ ❑ Kidney disease . . . . if yes, relation to patient ____________________

❑ ❑ ❑ Other . . . . if yes, what and relation to patient ____________________

SOCIAL HISTORY:

Do you drive? . . . . ❑ Yes ❑ No

Do you drink alcohol? . . . . ❑ Yes ❑ No; if yes, how many glasses a day ____________________

Do you use tobacco products? . . . ❑ Yes ❑ No; if yes, how much daily ____________________

Any history of venereal disease? . . ❑ Yes ❑ No Are you HIV positive? . . . . ❑ Yes ❑ No

Are you currently pregnant? . . . . . ❑ Yes ❑ No Planning on becoming pregnant in the next 6 months? . ❑ Yes ❑ No

OTHER:

Have you had an influenza vaccine in the past year? . . . . ❑ Yes ❑ No

Have you ever had a pneumonia vaccine? . . . . ❑ Yes ❑ No

Have you had a mammogram in the past 2.3 years? . . . . ❑ Yes ❑ No

if yes, were the results ❑ normal or ❑ abnormal

Have you had a colonoscopy in the past 9 years? . . . . ❑ Yes ❑ No

if yes, were the results ❑ normal or ❑ abnormal

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X ____________________ **X** __________ **X** ____________________ **X** __________

Signature of patient ***(Parent or Guardian if Minor)*** **Date** **Reviewed by** **Date**

Your eyes will be dilated. Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

I have read and understand the above statement.

X ____________________ **X** __________

Signature of patient ***(Parent or Guardian if Minor)*** **Date**