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

Retina Consultants, P.C.

Marion Joseph Stoj, M.D. • Jerry Neuwirth, M.D. • Peter H. Judson, M.D. • Michael S. Ruddat, M.D. • Andrew J. Packer, M.D. • Ron Margolis, M.D.

Consent and Acknowledgement Form

I consent to the use or disclosure of my protected health information by Retina Consultants, P.C. to any person or organization for the purpose of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by Retina Consultants, P.C. may include HIV / AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how Retina Consultants, P.C. will use and disclose my information can be found in Retina Consultant's P.C. Notice of Privacy Practices. I understand that this consent is effective for as long as Retina Consultants P.C. maintains my protected health information.

By signing below, I understand and acknowledge the following:

- I have read and understand this consent; and
- I have received Retina Consultant's P.C. Notice of Privacy Practices currently in effect.

_____

Print Name of Individual or Personal Representative

_____ _____

Signature of Individual or Personal Representative Date

If signed by the individual's representative, describe the legal authority of the representative to act on behalf of the individual: _____

Unable to obtain written consent and acknowledgement because:

- ☐ Individual refused
- ☐ Emergency treatment situation
- ☐ Individual not able to sign due to incompetence or other medical reason
- ☐ Other: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI) AND OBTAIN AND USE PRESCRIPTION HISTORY

1. With your permission, we may disclose your PHI to the individuals identified below. I authorize Retina Consultants, PC to release any personal information relating to my health care

   To:_____ Relationship to Patient:_____

   To:_____ Relationship to Patient:_____

2. I understand that I have the right to restrict information that may be released, and that this restriction must be in writing. (Please initial below)

   _____ No restrictions

   _____ With restrictions (list): _____

3. I agree that Retina Consultants, PC may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

4. I have received a copy of the Notice of Privacy Practices for Retina Consultants, PC, and I acknowledge that I am familiar with and understand the terms and conditions.

Name (printed) _____

_____ _____

Signature Date

AUTHORITY FOR TREATMENT

IF PATIENT IS A MINOR, FILL IN THE FOLLOWING INFORMATION

No child under the age of 16 (sixteen) may be left unattended!

I hereby authorize the providers at Retina Consultants, PC to examine, diagnose and treat the person listed below, for whom I am legally authorized to give consent. I authorize such services that the provider feels are necessary or advisable and are rendered under the provider's general or specific instructions.

Patient Name:_____ Patient's Date of Birth: _____

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Name (printed): _____ Date:_____

Relationship to Patient: _____

If parents are divorced, who is the custodial parent? ☐ Mother ☐ Father ☐ Both (Joint Custody)

Has a legal guardian been appointed? ☐ Yes ☐ No If yes, specify name _____