

NEW PATIENT REGISTRATION

Please Complete this Form: Please assist us in obtaining complete information so that we may successfully bill your insurance company. Any missing information may cause a delay in the billing process.

Patient Name: _____ DOB: _____

Address: _____ SSN: _____

_____ Sex: Male Female

Home Phone: _____ Mobile Phone: _____

Emergency Contact No./Relationship: _____

Marital Status: Single Married Divorced Legal Separated Widowed Other

Eye Doctor/Referring MD DO OD

Name: _____ Phone: _____

Address: _____ Zip: _____

Primary Medical Doctor MD DO OD

Name: _____ Phone: _____

Address: _____ Zip: _____

Other Doctor MD DO OD

Name: _____ Phone: _____

Address: _____ Zip: _____

Primary Insurance: _____ ID Number: _____

Group Number: _____ Effective Date of Coverage: _____

Subscriber Information (IF OTHER THAN YOURSELF)

Name _____ Date of Birth _____ Relationship _____

Secondary Insurance: _____ ID Number: _____

Group Number: _____ Effective Date of Coverage: _____

Subscriber Information (IF OTHER THAN YOURSELF)

Name: _____ Date of Birth _____ Relationship _____

Insurance Authorization: I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare or any private health plan to: Retinovitreal Associates/Associated Retinal Surgeons. This assignment is considered as valid as an original. I understand that I am financially responsible for any amount not covered by insurance or any amount deemed the subscriber's responsibility as defined by my insurance company, particularly co-payments and deductibles.

SIGNATURE: _____ DATE: _____

REVIEW OF SYSTEMS: PAGE 1

Patient Name: _____ **Date:** _____

Who referred you here today?

Name: _____ **Phone:** _____

Address: _____
Street City/State/Zip

Who is your Medical Doctor?

What are you being treated for?

Name: _____

Treated for: _____

Address: _____
Street City/State/Zip

Phone#: _____

Pharmacy Name: _____

Phone No.: _____

What eye problems have you had in the past?

Cataract surgery: Right eye (date) _____ Left eye (date) _____

Retinal surgery: Right eye (date) _____ Left eye (date) _____

Macular Degeneration: _____ Prior treatment _____

Glaucoma: _____ Prior treatment _____

Diabetic Retinopathy: _____ Prior treatment _____

Other: _____

Please check any of the items below that you may be allergic to, or list as needed.

List all Allergies: None Penicillin Sulfa Fluorescein

Shellfish Latex Iodine

Other: _____

Please complete the following Medication Sheet with any medications you are currently taking including vitamins and any non-prescribed herbal medicine.

REVIEW OF SYSTEMS: PAGE 2

Social History

What is your occupation? _____ Are you still working? Yes No

Do you smoke cigarettes/cigars? Yes No Number per day: _____ Years Smoked: _____

Do you drink alcohol? Yes No How much? _____ How often? _____

Do you exercise? Yes No What kind? _____ How often? _____

Do you have or have you ever had any pets? Yes No What kind? _____

Past and present drug use (legal or illegal) is important for drug and anesthetic interactions.

Please indicate if we need to be aware of this: Yes No

Have you had a blood transfusion since 1977? Yes No When? _____

Any Recent Surgeries? Yes No When? _____

Family Medical History

Have any blood relatives had any of the following medical problems? Please check "yes" or "no" for each problem and list who had that condition (write down "mother", "brother" etc. next to the condition they have or had):

Yes No Diabetes _____ Yes No Tuberculosis _____

Yes No Thyroid disease _____ Yes No Heart Disease _____

Yes No Stroke _____ Yes No High Blood _____

Yes No Anemia _____ Yes No Kidney disease _____

Yes No Hepatitis _____ Yes No Other _____

Yes No Cancer (type) _____ Yes No I do not know my family history

Other: _____

Family Eye History

Have any members of your family had any of the following eye problems?

Yes No Retinal Detachment _____ Yes No Glaucoma _____

Yes No Diabetic Retinopathy _____ Yes No Cataract _____

Yes No Macular Degeneration _____ Yes No Other significant eye disease _____

Is there anything not mentioned on this form you would like the doctor to be aware of?

Your eyes will be dilated for your eye exam. Dilation will make the pupils of your eyes large for several hours and can cause; light sensitivity, glare and blurred vision. Dark glasses are required. If you do not have your own, please ask us for a pair.

PATIENT SIGNATURE: _____ DATE: _____

PAST MEDICAL HISTORY

Have you had any medical problems in any of the following areas? Please check any problem areas and explain. Check "No" if you have not had any problem.

General (constitutional)

- Yes No Weight loss _____
 Yes No Lack of energy _____
 Yes No Trouble sleeping _____
 Yes No Other _____

Eyes

- Yes No Vision loss _____
 Yes No Any change in vision _____
 Yes No Eye pain _____
 Yes No Other _____

Ears, Nose, Mouth, Throat

- Yes No Hearing loss _____
 Yes No Sinus problem _____
 Yes No Infections _____
 Yes No Other _____

Heart & Blood Vessels (Cardiovascular)

- Yes No Heart attack _____
 Yes No High blood pressure _____ yrs _____
 Last blood pressure _____
 Yes No Heart murmur _____
 Yes No Irregular heart beat _____
 Yes No Mitral valve prolapsed _____
 Yes No Chest pain _____
 Yes No Circulation problems _____
 Yes No Other _____

Lungs (Respiratory)

- Yes No Asthma _____
 Yes No Bronchitis _____
 Yes No Shortness of breath _____
 Yes No Emphysema _____
 Yes No Tuberculosis _____
 Yes No Other _____

Stomach & Intestines (Gastrointestinal)

- Yes No Ulcers _____
 Yes No Diverticulitis _____
 Yes No Constipation _____
 Yes No Hepatitis _____
 Yes No Other _____

Kidney, Bladder, Prostate (Genitourinary)

- Yes No Kidney infections _____
 Yes No Urinary infections _____
 Yes No Cancer _____
 Yes No Other _____

Bones, Joints, Muscles (Musculoskeletal)

- Yes No Osteoporosis _____
 Yes No Arthritis _____
 Yes No Muscle Pain _____
 Yes No Other _____

Skin/Breast (Integumentary)

- Yes No Keloid scarring _____
 Yes No Rashes, sensitivities _____
 Yes No Skin Cancer _____
 Yes No Breast Cancer _____

Nervous System & Brain (Neurological)

- Yes No Seizure _____
 Yes No Stroke _____
 Yes No Paralysis/weakness _____
 Yes No Numbness _____
 Yes No Migraines _____
 Yes No Other _____

Mental Illness (Psychiatric)

- Yes No Depression _____
 Yes No Psychosis _____
 Yes No Mania, bipolar _____
 Yes No Schizophrenia _____
 Yes No Other _____

Endocrine System

- Yes No Diabetes _____
 Yes No Thyroid condition _____
 Yes No Other _____

Blood (Hematologic/Lymphatic)

- Yes No Anemia (low blood count) _____
 Yes No Excessive bleeding _____
 Yes No Bruising easily _____
 Yes No Clotting problems _____
 Yes No Other _____

Allergic/Immunologic

- Yes No Lupus _____
 Yes No Arthritis _____
 Yes No HIV _____
 Yes No Other _____

Diabetes

- When diagnosed with diabetes? _____
 Are you on insulin? _____ X per day? _____
 What is your Hgb A1C? _____
 Recent range: From _____ To _____
 Do you test at home? _____
 Are you on Kidney dialysis? _____

PATIENT SIGNATURE: _____

DATE: _____