

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: _____