Please fill out all of the attached forms. It is very important that we receive all of the information requested, so we can properly communicate with your referring doctor, your primary care doctor and especially, care for you. It is also important that all insurance information be kept up to date so that our billing department can successfully complete all the insurance billing and pre-cert procedures in a timely manner.

Thank you for your cooperation in filling out these forms.

Special Notes About your Office Visit:
*Your eyes will be dilated for the examination, so you may need someone to drive you.
*Your visit may last between 1 and 3 hours depending on the type of evaluation.
*Diabetic Patients are asked to bring a snack incase the appointment runs into their lunch or dinner time.
*Please refrain from wearing perfume or cologne as others may have allergies.
*For those patients in wheelchairs, please ensure you have an aid or family member to aid you during your visit.

Please Bring The Following With You On The Day of Your Appointment:
___ The completed forms attached.
___ A list of all medications and eye drops that you are presently taking including strengths and dosages.
Also, your pharmacy information including phone number.
___ Your current insurance cards.
___ Copays for specialists as noted on you insurance cards.
___ Referrals from your primary care physician if your insurance requires a referral to see a specialist.

NOTE: Without a proper referral, payment will be due at the time of the office visit.
___ A valid picture identification, valid ID

NOTE: If Medicare is your only insurance, a co payment will be collected at the time of the office visit. If your insurance is non par, payment will be collected at the time of the office visit.

Please feel free to contact us toll free at 800-331-6634 with any questions.
For directions and other information visit our website midatlanticretina.com
Last Name: ____________________________  First Name: ____________________________  MI: ______

Address: __________________________________ City: __________________ State: ______ Zip: __________

Home Phone: __________________________ □ Work □ Cell Phone: __________________________

Email: ____________________________  Preferred Language: ____________________________

Emergency Contact/Relationship: ____________________________ Phone: ____________________________

DOB: _____________ Social Security No: _______-_______-_______ Gender: □ Male □ Female

Pharmacy Name/Address: __________________________________________ Phone: ____________________________

Marital Status: □ Single □ Married □ Legally Separated □ Divorced □ Widowed □ Other

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native American or Other Pacific Islander □ White □ Decline to Answer

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown

Referring Physician □ MD □ OD □ DO

Name: __________________________________________ Phone: ____________________________

Address: __________________________________________ Zip: ____________________________

Primary Care Physician □ MD □ OD □ DO

Name: __________________________________________ Phone: ____________________________

Address: __________________________________________ Zip: ____________________________

Other Physician □ MD □ OD □ DO

Name: __________________________________________ Phone: ____________________________

Address: __________________________________________ Zip: ____________________________

Primary Insurance: __________________________ Effective Date of Coverage __________________________

ID No: __________________________ Group No: __________________________

Subscriber: __________________________ DOB: __________________________ Relationship: __________________________

Secondary Insurance: __________________________ Effective Date of Coverage __________________________

ID No: __________________________ Group No: __________________________

Subscriber: __________________________ DOB: __________________________ 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 Retinovitreous Associates/Associated Retinal Surgeons d/b/a Mid Atlantic Retina. 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 (check all that apply)

Constitutional (General)
___ Jaw Pain
___ Fever
___ Weight Loss
___ Fatigue
___ Loss of Appetite
___ Trouble Sleeping
___ Other

HENT (Ears/Eyes/Nose/Throat)
___ Hearing Loss
___ Sore throat
___ Runny Nose
___ Vision Loss
___ Other

Cardiovascular
___ Cardiovascular Disease
___ Heart Attack
___ Heart Murmur
___ Hypertension
___ Irregular Heart Beat
___ Mitral Valve Prolapse
___ Chest Pain
___ Swelling of Feet
___ Other

Respiratory
___ Asthma
___ Bronchitis
___ Emphysema
___ Sarcoidosis
___ Tuberculosis
___ Wheezing
___ Cough
___ Shortness of Breath
___ Other

Endocrine
___ Diabetes
___ Thyroid Condition
___ Excessive Thirst
___ Excessive Urination
___ Cold Intolerance
___ Heat Intolerance
___ Other

Gastrointestinal
___ Diverticulitis
___ Hepatitis
___ Ulcers
___ Constipation
___ Abdominal Pain
___ Nausea
___ Diarrhea
___ Other

Hematology/Oncology
___ Anemia
___ Blood Clots
___ Easy Bruising
___ Prolonged Bleeding
___ Clotting problems
___ Other

Genitourinary
___ Cancer
___ Kidney Infections
___ Urinary Infections
___ Pain/Burning with urination
___ Other

Integumentary (Skin/Breast)
___ Skin Cancer
___ Keloid Scarring
___ Rash
___ Change in Mole
___ Other

Musculoskeletal
___ Arthritis
___ Osteoporosis
___ Muscle Aches
___ Joint Pain
___ Difficulty laying flat
___ Other

Neurologic
___ Alzheimer's
___ Migraines/Headaches
___ Neurofibromatosis
___ Seizure
___ Stroke
___ Weakness
___ Paralysis of Extremities
___ Scalp Tenderness
___ Dizziness
___ Tremor
___ Other

OTHER
___ Depression
___ Mania/Bipolar
___ Schizophrenia
___ Psychosis
___ Hypercholesterolemia
___ HIV
___ Lupus
___ Lyme Disease
___ Multiple Sclerosis

OTHER
___ Marfan's Syndrome
___ Myasthenia Gravis
___ Juvenile Rheumatoid Arthritis
___ Sjogren's Syndrome
___ Steroid Therapy (long term)
___ Stevens-Johnson Syndrome
___ Stickler Syndrome
___ Temporal Arteritis
___ Von Hippel-Lindau Syndrome

PATIENT SIGNATURE ____________________________ DATE ____________
NAME: ________________________________ DOB: _______________

SURGERIES: Please list prior surgeries and date performed:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

MEDICATIONS: Please list your current medications, with dosage and strength:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

EYE DROPS: Please list EYE DROPS you are currently taking (include times per day):

RIGHT EYE: ______________________________________________________________
________________________________________________________________________
________________________________________________________________________

LEFT EYE: ________________________________________________________________
________________________________________________________________________
________________________________________________________________________

ALLERGIES: Please check off any items below that you may be allergic to or list as needed.

☐ NONE ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Shellfish
☐ Latex ☐ Iodine ☐ Morphine ☐ Aspirin ☐ Fluorescein

OTHER: _________________________________________________________________

FAMILY MEDICAL HISTORY

Have any blood relatives had any of the following medical problems? List who had that condition (i.e. mother, brother

Arthritis ___________ Y N  Anemia _______________ Y N
Blindness ___________ Y N  Heart Disease _____________ Y N
Cancer (type) ___________ Y N  Hepatitis _____________ Y N
Diabetes ___________ Y N  Hypertension _______________ Y N
Diabetic Retinopathy ___________ Y N  Kidney Disease _____________ Y N
Cataract ___________ Y N  Retinal Detachment _____________ Y N
Stroke ___________ Y N  Tuberculosis _______________ Y N
Thyroid Disease ___________ Y N  Uveitis _______________ Y N
Macular Degeneration ___________ Y N  OTHER: ___________________ Y N

PATIENT SIGNATURE: ________________________________ DATE: _______________
NAME: ________________________________ DOB: __________

SOCIAL HISTORY

Marital Status:  □ Married  □ Single  □ Widow/Widower  □ Divorced  □ Separated
Do you smoke cigarettes/cigars?  □ Yes  □ No  Number per day: _______ Years: ______
Do you drink alcohol?  □ Yes  □ No  How much?_______ How often? ______
Past and Present drug use (legal/illegal) is important for drug and anesthetic interactions. Please indicate if we need to be aware of this:  □ Yes  □ No
What is your occupation?______________________________
Are you still working? ______________

Have you ever had a blood transfusion since 1977?  □ Yes  □ No  When? ______________
Living Conditions:  □ Alone  □ Nursing Home  □ Caretaker/Family  □ Other
Do you have or have you ever had any pets?  □ Yes  □ No  What kind?______________________________
Do you exercise?  □ Yes  □ No  What kind? ____________________________ How often? __________

DIABETICS

When diagnosed? ______________ What type?  □ Type I  □ Type II
Type II Insulin dependent?  □ Yes  □ No
What is your Hemoglobin A1C? ______________  Date of your most recent HgbA1C? ____________
Do you test at home?  □ Yes  □ No  Recent range: From___________ to___________
Are you on dialysis?  □ Yes  □ No

Please list prior EYE surgeries:

cataract surgery:  right eye (date) __________________
                    left eye (date) __________________
retinal surgery:  right eye (date) __________________
                    left eye (date) __________________

Please list any prior eye problems & treatments:

Y N Glaucoma
Y N Macular Degeneration
Y N Diabetic Retinopathy
Y N Other ____________________________

PATIENT SIGNATURE: ____________________________  DATE: ____________