

## Patient Registration

Today's date: \_\_\_\_\_

Patient Information			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Please check Primary form of contact:	Home Phone <input type="checkbox"/>	Work Phone <input type="checkbox"/>	Cell Phone <input type="checkbox"/>
Other Name(s) Used		E-mail Address	
Gender <input type="checkbox"/> M <input type="checkbox"/> F	SSN	Preferred Language	Who referred you
Marital Status	Preferred Contact	Ethnicity	Race
<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Life Partner	<b>Which form of communication do you approve for us to contact you?</b> <input type="checkbox"/> Mail <input type="checkbox"/> Home Phone <input type="checkbox"/> Day Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Patient Portal	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> unknown/or decline to answer	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other (decline to answer)
Primary Care Provider name	Referring Provider name	Cardiologist name	Endocrinologist Provider name
Address	Address	Address	Address
Responsible Party (Guarantor)		Same as patient <input type="checkbox"/>	
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Please check Primary form of contact:	Home Phone	Work Phone	Cell Phone
SSN	Relationship to Patient	Preferred Language	Driver's License
Emergency Contact (for minor child, this section may be used for other parent)			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Please check Primary Phone	Home Phone <input type="checkbox"/>	Work Phone <input type="checkbox"/>	Cell Phone <input type="checkbox"/>
Insurance information (Please complete all details)			
Primary insurance	ID # and Group #	DOB	Subscriber and relationship
Secondary insurance	ID # and Group #	DOB	Subscriber and relationship
I/We do hereby consent to and authorize the performance of all medical services and treatments deemed advisable by the physicians and staff of Mid Atlantic Retina (MAR) to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained herein are true. I understand that, although the providers of MAR may or may not participate with my insurance carrier(s), I am financially responsible for any co-payments, deductibles, and payment for non-covered services or out of network services incurred for myself and/or my dependent(s). I furthermore agree to pay accrued interest, if applicable, collection expenses, and reasonable attorneys' fees incurred to collect any amount I may owe. I also hereby authorize MAR to release information as necessary for and/or requested by the insurance company and/or its representatives for claims processing and payment. I fully understand this agreement and consent will continue until cancelled by me in writing.			
Signature of Patient/Responsible Party		Date	
Name of Patient/Responsible Party (Please Print)		Relationship to Patient	

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Pharmacy Information**

Preferred Pharmacy		Secondary Pharmacy	
Name		Name	
Address		Address	
Phone		Phone	
Fax		Fax	

**Advanced Directives**

None  
  Do Not Resuscitate  
  Durable  
  Power of Attorney  
  Living Will  
  HC Proxy

**Date Reviewed:**

**Medications - List all medications you take, prescription and non-prescription, and the dosage**

I do not take any medications

Medication Name	Dosage/Strength	Medication Name	Dosage/strength

**Medication and Food Allergies - List all known allergies (drugs, food, animals, etc.)**

No Known Allergies


**Family History - Check if any family member(s) has had any of the following conditions.**

Adopted

Diagnosis	
Anemia	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other: _____
Arthritis	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other: _____
Blindness	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other: _____
Cancer (type)	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other: _____
Cataract	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other: _____
Diabetes	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other: _____
Diabetic Retinopathy	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other: _____
Glaucoma	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other: _____
Heart Disease	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other: _____
Hepatitis	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other: _____
Hypertension	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other: _____
Kidney Disease	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other: _____
Macular Degeneration	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other: _____
Retinal Detachment	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other: _____
Stroke	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other: _____
Tuberculosis	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other: _____
Thyroid Disease	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other: _____
Uveitis	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other: _____

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Medical History - Check if you have ever experienced the following conditions, and year of onset.			
Condition	Year	Condition	Year
<input type="checkbox"/> None		<input type="checkbox"/> Lyme Disease <b>With Arthritis</b> <input type="checkbox"/> Y	
<input type="checkbox"/> Alzheimers		<input type="checkbox"/> Mania/Bipolar	
<input type="checkbox"/> Amputation Location: _____		<input type="checkbox"/> Marfan's Syndrome	
<input type="checkbox"/> Anemia		<input type="checkbox"/> Migraines	
<input type="checkbox"/> Arthritis <b>Rheumatoid?</b> <input type="checkbox"/> Y Location: _____		<input type="checkbox"/> Mitral Valve Proplapse	
<input type="checkbox"/> Asthma		<input type="checkbox"/> <b>Multiple Sclerosis</b>	
<input type="checkbox"/> Atrial Fibrillation		<input type="checkbox"/> <b>Myasthenia Gravis</b>	
<input type="checkbox"/> Blood Clots		<input type="checkbox"/> Neurofibromatosis Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2	
<input type="checkbox"/> Bronchitis		<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Cancer - Type : _____		<input type="checkbox"/> Psychosis	
<input type="checkbox"/> Cardiovascular Disease		<input type="checkbox"/> Sarcoidosis: <input type="checkbox"/> Lung <input type="checkbox"/> Lymph Node <input type="checkbox"/> Lung & Lymph nodes <input type="checkbox"/> Other: _____	
<input type="checkbox"/> COPD		<input type="checkbox"/> Schizophrenia	
<input type="checkbox"/> <b>Crohn's Disease</b>		<input type="checkbox"/> Seizure	
<input type="checkbox"/> Depression		<input type="checkbox"/> <b>Sickle Cell:</b> <input type="checkbox"/> Anemia <input type="checkbox"/> Hb-C	
<input type="checkbox"/> <b>Diabetes (see questions below)</b>		<input type="checkbox"/> Sinusitis	
<input type="checkbox"/> Diverticulitis		<input type="checkbox"/> <b>Sjogren's Syndrome</b>	
<input type="checkbox"/> Emphysema		<input type="checkbox"/> Steroid Therapy (long term)	
<input type="checkbox"/> <b>ESRD</b>		<input type="checkbox"/> <b>Stevens-Johnson Syndrome</b>	
<input type="checkbox"/> Hearing Loss		<input type="checkbox"/> Stickler Syndrome	
<input type="checkbox"/> Heart Attack		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Heart Murmur		<input type="checkbox"/> Thyroid condition	
<input type="checkbox"/> Hepatitis (Type) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C		<input type="checkbox"/> Temporal Arteritis	
<input type="checkbox"/> <b>HIV</b>		<input type="checkbox"/> Transplant Recipient <input type="checkbox"/> Kidney <input type="checkbox"/> Heart <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Pancreatic <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Hypercholesterolemia		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Hypertension		<input type="checkbox"/> <b>Ulcerative Colitis</b>	
<input type="checkbox"/> Irregular Heart Beat		<input type="checkbox"/> Ulcers	
<input type="checkbox"/> <b>Juvenile Rheumatoid Arthritis</b> Location: _____		<input type="checkbox"/> Urinary Infections	
<input type="checkbox"/> Kidney Disease Stage: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		<input type="checkbox"/> <b>Von Hippel-Lindau Syndrome</b>	
<input type="checkbox"/> <b>Lupus</b>		<input type="checkbox"/> Other	
Diabetes			
<b>Diabetes Type:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 Year Diagnosed _____ Are you on insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No x per day _____			
What is Hgb A1C? _____ Recent Range: From _____ to _____ Do you test at home? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you on dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency? _____/week			

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Please list any prior eye problems & treatments:**

- Y  N Glaucoma treatment: \_\_\_\_\_
- Y  N Macular Degeneration treatment: \_\_\_\_\_
- Y  N Diabetic Retinopathy treatment: \_\_\_\_\_
- Y  N Other treatment: \_\_\_\_\_

**Surgical History - Check if you have received the following procedures, and year performed.**

Non- Ocular Surgeries		Ocular Surgeries	
Surgical Procedure	Date	Cataract Surgery	Date
		Right eye	
		Left eye	
		Retinal Surgery	
		Right Eye	
		Left Eye	
		Other:	

**Social History**

Marital Status:  Married  Single  Widow/Widower  Divorced  Separated

Do you smoke cigarettes/cigars?  yes  no Number per day: \_\_\_\_\_ Years Smoked: \_\_\_\_\_ Year quit: \_\_\_\_\_

Do you drink alcohol?  yes  no How much? \_\_\_\_\_ How often? \_\_\_\_\_

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

What is your occupation? \_\_\_\_\_ Are you still working?  yes  no

Have you 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? \_\_\_\_\_

**Review of Systems (check all that apply)**

<b>Constitutional</b> <input type="checkbox"/> Jaw Pain <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Trouble Sleeping <input type="checkbox"/> Other	<b>Cardiovascular</b> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Swelling of Feet	<b>Endocrine</b> <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Excessive Urination <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Other	<b>Gastrointestinal</b> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Other
<b>HENT</b> <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Sore Throat <input type="checkbox"/> Runny Nose <input type="checkbox"/> Other	<b>Neurologic</b> <input type="checkbox"/> Weakness <input type="checkbox"/> Headaches <input type="checkbox"/> Scalp Tenderness <input type="checkbox"/> Dizziness <input type="checkbox"/> Paralysis of Extremities <input type="checkbox"/> Tremor	<b>Genitourinary</b> <input type="checkbox"/> Pain/Burning with Urination <input type="checkbox"/> Other	<b>Integumentary</b> <input type="checkbox"/> Rash <input type="checkbox"/> Change in Mole
<b>Respiratory</b> <input type="checkbox"/> Wheezing <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Other	<b>Hematology / Oncology</b> <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Prolonged Bleeding <input type="checkbox"/> Clotting Problems <input type="checkbox"/> Other	<b>Musculoskeletal</b> <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Joint Pain <input type="checkbox"/> Difficulty Laying Flat from Muscular Discomfort	