

Welcome

Thank you for choosing Retina Consultants of Southwest Florida. Please provide us with the information requested below. See a staff member if you need any assistance completing this form.

Name _____
Last First Middle

Birthdate: ____ / ____ / ____ Sex: M F (please circle)

Patient's Social Security Number: _____

Local Address:

Street City State Zip

Home Phone (____) _____ Cell Phone (____) _____

Mailing Address, if different:

P.O. Box City State Zip

Northern Address:

Street City State Zip

Northern Phone: (____) _____

The following information is collected per Federal Government regulation in the Health Information Technology Act (HITECH ACT). Your response is optional.

Race: American Indian or Alaskan Native Asian Black or African American
 More than one Native Hawaiian or Pacific Islander White Unreported/Not Known

Primary Language Spoken: _____

Ethnicity: Hispanic or Latino Not Reported Not Hispanic or Latino

Please turn page and complete reverse side

General Eye Doctor:
(please provide address if not local)

Primary Care / Family Physician:

Pharmacy Information:

Name: _____ **Phone:** _____

Address: _____

Many times patients want us to be able to discuss their medical care with family members or friends. Please list all people that we are permitted to discuss these matters with.

1. _____ Relationship _____ Date of Birth: _____

2. _____ Relationship _____ Date of Birth: _____

3. _____ Relationship _____ Date of Birth: _____

Please indicate someone we may contact other than your spouse for emergency purposes.

Name: _____ **Date of Birth:** _____

Phone: (____) _____

Relationship: _____

Often times, people find it convenient for us to leave test results on their answering machine. May we leave test results on your answering machine?

Yes No (please circle)

Insurance Information

Please provide us with your complete insurance information below. If the primary subscriber is someone other than the patient, please indicate.

Primary Insurance Company: _____

Address: _____

Phone: (____) _____

Subscriber/Member's Name: _____

Subscriber's Date of Birth: _____

Subscriber's Social Security Number: _____

Policy ID/Group and Contract Numbers: _____

If Workman Compensation Claim, please provide:

Employer's name (if applicable): _____

Employer's Address: _____ Phone # _____

Supplemental Insurance Company: _____

Address: _____

Phone:(____) _____

Subscriber/Member's Name: _____

Subscriber's Date of Birth: _____

Subscriber's Social Security Number: _____

Policy ID/Group and Contract Numbers: _____

Please turn to next page

Apply Label Here

Patient Acknowledgment & Consent

I understand that in the course of my care and treatment by Retina Consultants of Southwest Florida, medical reports will be created. I consent to Retina Consultants sending any reports regarding my evaluation, treatment, and follow-up care to any other health care providers involved in any of my care and treatment, including the doctor requesting the consultation with Retina Consultants and my family physician. I understand that in the course of my treatment, the physicians at Retina Consultants may have to review medical reports and records from other health care providers and consent to Retina Consultants requesting and receiving those records they deem necessary.

I understand that in order to facilitate insurance or other third-party reimbursement for my care and treatment, that Retina Consultants or its agents may have to share information about me with my insurance company or third-party payment source or their agents or employees (including my employer, if this is a worker's compensation claim). I consent to Retina Consultants sharing the information necessary to properly process claims for reimbursement.

I hereby assign my right to be reimbursed out of any insurance policy or from any person or organization that is or may become liable to me for any of the costs or fees associated with my care and treatment to Retina Consultants and authorize payment directly to Retina Consultants.

I understand and agree that I am individually obligated to pay for the care and treatment provided to me, including outstanding balances not covered by any insurance policy or other third-party payment source such as Medicare. I understand and agree that if I do not pay any amounts due, that I will be liable for any costs and fees associated with collecting those amounts, including attorney's fees and court costs, if any.

Signature

Date

**Review of Systems -
Medical History Form**

Date: _____ Chart #: _____

Patient Name: _____

Please check each item Yes or No as they relate to your health

	Yes	No		Yes	No		Yes	No
EYES			ENDOCRINE			NERVOUS SYSTEM / BRAIN		
Double Vision			Diabetes - Type I or Type II			Seizures/Epilepsy		
Pain			<i>How long?:</i> _____			Numbness		
Floater or Spots			Thyroid			Stroke - <i>When:</i> _____		
Seeing Flashes of light						Alzheimer's		
Dry Eyes			CANCER					
Decreased Vision			Location: _____			PSYCHIATRIC		
Sandy/Gritty Feeling			Radiation <input type="checkbox"/> Chemotherapy <input type="checkbox"/>			Anxiety/Depression		
Excessive Tearing						Mood Swings/Difficult Sleep		
			GENERAL HEALTH					
BLOOD / LYMPH			Weight Loss			KIDNEY / BLADDER / URINARY		
Anemia			Fatigue			Prostate		
Easy Bruising			Fever			Urination difficulty		
Prolonged Bleeding						Bladder		
Use blood thinners?			STOMACH / INTESTINES			Kidney-Dialysis		
			Stomach problems			Dialysis - # of times: _____ wk		
MUSCULOSKELETAL			Liver Problems					
Arthritis						EAR, NOSE, MOUTH, THROAT		
			CARDIOVASCULAR			Hearing – loss / problems		
ALLERGIC/IMMUNOLOGIC			Murmur			Mouth (dentures)		
Hay Fever			Chest Pain / Angina			Sinus		
			Palpitations					
LUNGS / RESPIRATORY			Heart Attack -			SKIN		
Cough			<i>when:</i> _____			Skin rashes		
Wheezing			High Blood Pressure			Ulcers		
Emphysema			Hand or Ankle Swelling			Swelling		
Asthma								

PAST MEDICAL / SURGICAL HISTORY:

List Your Other Illnesses not listed above	List Your Past Surgeries	Date

- Married Widowed Single Divorced Number of Children: _____
 Non-Smoker Smoker - # of packs per day? _____ No Alcohol Alcohol - Number of drinks per day? _____

Family/Social History: Check Yes or No as related to your Family History. Explain positive responses. ie: Mother, Father, Sister, Brother, Grandparents.

	YES	NO	Family Member		YES	NO	Family Member
Glaucoma:				Diabetes:			
Cataract:				Hypertension:			
Retinal:				Vascular:			
Cardiac:				Cancer:			

Other Pertinent Medical Information:

Turn Page over – continue

Review of Systems / Medical History Form

Date: _____ **Chart #:** _____

Patient Name: _____

Allergies: - Please list all

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

Current Medications – Please complete the list below by adding the dosage you take per day. If your medication is not already listed we have provided an area below that you can complete. Please fill in the name, dosage and circle "Rx" - Prescription medication or "OTC" Over the Counter medication.

Prescription Medication Name / Dosage / amount taken per day:

Blood Thinner: N/A _____ x per day

Aspirin _____ x per day

_____ x per day Rx OTC _____ x per day Rx OTC

_____ x per day Rx OTC _____ x per day Rx OTC

_____ x per day Rx OTC _____ x per day Rx OTC

_____ x per day Rx OTC _____ x per day Rx OTC

_____ x per day Rx OTC _____ x per day Rx OTC

_____ x per day Rx OTC _____ x per day Rx OTC

_____ x per day Rx OTC _____ x per day Rx OTC

_____ x per day Rx OTC _____ x per day Rx OTC

_____ x per day Rx OTC _____ x per day Rx OTC

Patient Signature: _____ **Date:** _____

Technician Signature: _____ **Date:** _____