PATIENT REGISTRATION

Please print clearly.

LAST NAME:_____ FIRST NAME:_____ INITIAL:____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE: (____) _____ WORK PHONE: (____) _____

CELL PHONE: (____) _____ EMAIL:_____

DATE OF BIRTH:_____ AGE:_____ MALE FEMALE

SOCIAL SECURITY NUMBER:_____

WORK STATUS: PART-TIME FULL-TIME RETIRED FULL-TIME STUDENT

EMPLOYER:_____ OCCUPATION:_____

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

SPOUSE'S NAME:_____ DAY PHONE:_____

REFERRAL INFORMATION

REFERRING PHYSICIAN:_____

Specialty: (circle one) Ophthalmologist Optometrist Internist Family Practitioner

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____ PHONE: (___)_____

FAX: (___)_____

PRIMARY CARE PHYSICIAN:_____ PHONE: (___)_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____ PHONE: (___)_____

FAX: (___)_____

INSURANCE INFORMATION *Please present your insurance card to the receptionist*

*If an insurance card is not presented the balance will be transferred to the patient.

2 SIDES PLEASE

EMERGENCY CONTACT:_____

RELATIONSHIP TO PATIENT:_____DAY PHONE:_____

IF YOUR ILLNESS OR INJURY IS WORK RELATED, please provide:

DATE OF INJURY:_____

WORK COMP INFO:_____PHONE:_____

BENEFITS AND MEDICAL RELEASE AUTHORIZATION

Insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a substitute for payment. It is your responsibility to pay any deductible, co-payment or any balance not paid for by your insurance.

I hereby authorize payment of Medicare or other insurance benefits available for medical or surgical services to California Retina Consultants.

I authorize the release of any medical information requested by my insurance company concerning my illness, surgery or injury.

I understand that if I am a member of a Health Maintenance Organization (HMO), I am responsible for obtaining prior authorization from my Primary Care Physician for all visits and procedures performed in this office. I understand that if prior authorization is not obtained, I may be responsible for the charges incurred on that particular date of treatment. I understand that all co-payments are due at the time of the visit or procedure.

PATIENT NAME:_____
(Please print)

SIGNED:_____ DATE:_____

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been offered a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be located in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

The Notice of Privacy Practices will be offered to me at my first office visit.

_____ _____
Signed **Date**

Print Name:_____

Medical History Questionnaire

Name _____ **Date** _____

Date of birth _____ Date of last eye exam _____

Referring Dr. _____ Primary Care Physician _____

What is the chief complaint regarding your eyes?_____

_____

List any medications you currently take (prescription and over-the-counter):_____

_____

_____

Do you have allergies to any medications? □ YES □ NO If YES, list the medications:_____

_____

Have you ever taken Mellaril (Thioridazine), Chloroquine, Plaquenil, or Tamoxifen? □ YES □ NO

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.)

_____

_____

List any surgeries you have had (cataract, tonsils, appendix, etc.) _____

_____

Do you currently have any of the problems below? If YES please give details:

EYES	**RIGHT**	**LEFT**	**NO**	EXPLANATION OF PROBLEM
Loss of vision				
Distorted vision				
Loss of side vision				
Double vision				
Itching				
Tearing/watering				
Pain				
Crossed or lazy eye				
Drooping eyelid				
Cataract				
Glaucoma				
Flashes				
Floaters				
Retinal Tear				
Retinal detachment				
Retinal laser				
Eye trauma				

	YES	NO	EXPLANATION OF PROBLEM
GENERAL/CONSTITUTIONAL (Fever)			
(Weight loss)			
EARS, NOSE, THROAT (Sinus infections)			
(ear infection, chronic cough, dry mouth)			
CARDIOVASCULAR (Heart Attack)			
(High blood pressure)			
RESPIRATORY (Asthma)			
(Emphysema)			
GASTROINTESTINAL (Stomach ulcers)			
(Hepatitis)			
GENITAL, KIDNEY (Kidney stones)			
(Dialysis)			
MUSCLES, BONES, JOINTS (Arthritis)			
(Polymyalgia rheumatica)			
SKIN (Acne, warts, Vitiligo)			
NEUROLOGICAL (Stroke)			
(Multiple sclerosis)			
ENDOCRINE (thyroid)			
Diabetes [how long?]			
BLOOD/LYMPH (Cholesterol, anemia)			
(Taking blood thinners)			
INFECTIOUS DISEASE (Syphilis, TB, HIV)			
ALLERGIC/IMMUNOLOGIC (Lupus, Sjogrens)			
CANCER			

FAMILY HISTORY

M=Mother, F=Father, S=Sibling, GP=Grandparents

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Retinal Detachment			
Macular Degeneration			
Glaucoma			
Cancer			
Diabetes			

SOCIAL HISTORY

Current or prior occupation:_____

Education (high school, vocational school, college degree):_____

Marital Status (married, divorced, single, widowed):_____

Living Arrangements:_____

Do you drive? ☐ YES ☐ NO

Do you have visual difficulty when driving? ☐ YES ☐ NO

Do you have problems with night vision? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO If YES: occasional 1 per day 2-3/day 4+/day

Do you smoke? ☐ YES ☐ NO If YES: occasional 1 per day 2-3/day 4+/day

Have you ever had a blood transfusion? ☐ YES ☐ NO

History reviewed. ☐ No changes. ☐ Additions as noted above.

Physician's Signature:_____ Date:_____