Registration Information

I) Please complete the following forms PRIOR to your visit.

* Patient Medical History Form
* Patient Information Form
* Patient Consent for Use & Disclosure of Protected Health Information
* If you have a <u>separate medicine list</u> and/or your own printed medical history summary, please bring a copy for your records.

2) Our staff may contact you for a phone interview in advance of your appointment.
This will allow us to gather your patient information from the above forms prior to your arrival. *If you are unable to do the interview in advance, please bring the* ***<u>completed forms</u>*** *to your first office visit.*

3) Sign in at our reception desk. Please bring a photo ID and your medical insurance card(s). *If your insurance requires a referral; it is your responsibility to obtain this from your primary care doctor or referring physician* ***<u>prior to</u>*** *your appointment.*

What to expect

Your visit may last one to three hours, depending on the complexity of your problem, type of testing required, or if immediate treatment is needed. We will dilate your pupils to perform a thorough retinal exam. Side effects include blurred vision and light sensitivity, which may last several hours. We recommend you have transportation arranged for your trip home if you feel the dilation will affect your vision for driving.

Payment Information

If your insurance company requires a co-payment, this is due upon registration, prior to your exam. We accept cash, checks, VISA/MASTERCARD/DISCOVER/AMERICAN EXPRESS. If you are uninsured, please call our office **<u>PRIOR</u>** to your visit, so our patient account specialist can review our policies with you.

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PATIENT MEDICAL HISTORY

Name: ▢Mrs. ▢Ms. ▢Miss ▢Mr.____Date:_____________

Address:____

City:________________________________State:___________Zip:_________________Date of Birth:____________________

Have you had any of the following? (Explain YES answers below)

Laser eye surgery.............................. ▢Yes ▢No ____

Cataract surgery................................ ▢Yes ▢No ____

Retina surgery...................................▢Yes ▢No ____

Eye Infections.................................... ▢Yes ▢No ____

Glaucoma .... ▢Yes ▢No____

Other eye problems/surgery.............. ▢Yes ▢No ____

Do you have any of the following conditions?

Anemia................ ▢Yes ▢No Kidney problem .... ▢Yes ▢No Difficulty with urination................. ▢Yes ▢No

Arthritis................ ▢Yes ▢No Back or neck pain .... ▢Yes ▢No Chest pain/palpitations.................. ▢Yes ▢No

Headache .... ▢Yes ▢No Bleeding disorder................. ▢Yes ▢No Cough/shortness of breath.............▢Yes ▢No

Hearing loss.......... ▢Yes ▢No Dementia/Alzheimers.......... ▢Yes ▢No Stomach/intestinal problem...........▢Yes ▢No

Liver disease......... ▢Yes ▢No Recent weight change......... ▢Yes ▢No Depression/psychiatric problem.....▢Yes ▢No

Sinus trouble........ ▢Yes ▢No Rash or skin problems......... ▢Yes ▢No Numbness/tingling in fingers/toes..▢Yes ▢No

Fever or chills....... ▢Yes ▢No Mouth sores or disease ...... ▢Yes ▢No Physical Limitations......................... ▢Yes ▢No

Thyroid disease ... ▢Yes ▢No Fatigue/overall weakness... ▢Yes ▢No

Date of onset

Autoimmune Conditions................▢Yes ▢No ____________________________________ ______________________

Infectious disease........................ ..▢Yes ▢No ____________________________________ ______________________

(HIV, AIDS, Hepatitis, Meningitis, MRSA, Shingles, Staph, TB)

High blood pressure....................... ▢Yes ▢No ____________________________________ ______________________

Diabetes.. ▢Yes ▢No .... ▢Type I ▢Type II ________________ ______________________

Lung disease .... ▢Yes ▢No ____________________________________ ______________________

High cholesterol............................ ▢Yes ▢No ____________________________________ ______________________

Cancer... ▢Yes ▢No ____________________________________ ______________________

Stroke/neurologic disorder............. ▢Yes ▢No ____________________________________ ______________________

Heart disease .... ▢Yes ▢No ____________________________________ ______________________

(Continued on other side)

Have you had a Flu Shot? ☐Yes ☐No (if so approximate date): ______________________________

Have you had a shingles Vaccine? ☐Yes ☐No

Do you have a living will? ☐Yes ☐No

List any other major illnesses, hospitalization and surgeries (with dates, if possible):

____

____

____

____

List all medications you currently take (name, dosage, frequency). If none, check here ☐.

Eye medications:

____

____

Other medications:

____

____

____

____

____

Are you allergic to any medications? ☐Yes ☐No (If YES, please list)

____

____

____

Have any family members or relatives had any of the following conditions? (list relationship to you below)

Glaucoma .... ☐Yes ☐No ______________________________

Macular degeneration..................... ☐Yes ☐No ______________________________

Retinal detachment......................... ☐Yes ☐No ______________________________

Diabetic Retinopathy .... ☐Yes ☐No ______________________________

Blindness.. ☐Yes ☐No ______________________________

Diabetes.. ☐Yes ☐No ______________________________

Heart disease .... ☐Yes ☐No ______________________________

Cancer.. ☐Yes ☐No ______________________________

Uveitis.. ☐Yes ☐No Autoimmune Conditions................ ☐Yes ☐No

Your occupation: ____ Retired ☐

Your employer:____

Marital Status:... ☐Married ☐Single ☐Widow(er)

Do you drive a car?..................................... ☐Yes ☐No

Can you read small print (newsprint)?............ ☐Yes ☐No

Do you smoke tobacco?................................ ☐Yes ☐No Current or previous use? ____________________

Do you drink alcohol?.................................... ☐Yes ☐No How often? ____________________

History of drug/substance abuse: .... ☐Yes ☐No Details ____________________

Primary care physician: ____

City: ______________________ State:__________ Name of Pharmacy: ____________________