PATIENT INFORMATION

PLEASE PRINT

LAST NAME:_____ **FIRST NAME:**_____ **MI:**_____

ADDRESS:_____ **CITY:**_____ **ST:**_____ **ZIP:**_____

PHONE: HOME(____)_____ **OCCUPATION:**_____

WORK(____)_____ **EMPLOYER:**_____

CELL(____)_____ **DRIVER'S LIC NUMBER:**_____

SOCIAL SECURITY #:_____ **MARITAL STATUS: Mrd Sngl Div Wid**

BIRTHDATE:_____ **AGE:**_____ **SEX: Male / Female**

EMAIL:_____

ARE YOU CURRENTLY LIVING AT A FACILIY: YES / NO IF YES- WHERE:_____

ARE YOU CURRENTLY IN HOSPICE: YES / NO

Language:English/Spanish/other_____

Ethnicity:Hispanic or Latino/ Not Hispanic or Latino

Race:American Indian/Asian/African American/Hispanic/Pacific Islander/White

NAME OF ALTERNATE PERSON TO CONTACT

NAME:_____ **PHONE:(____)**_____

RELATIONSHIP:_____ **ALTERNATE PHONE #:(____)**_____

THE FOLLOWING INFORMATION IS REQUIRED FOR US TO BE ABLE TO FILE WITH YOUR INSURANCE COMPANY:

INSURANCE POLICYHOLDERS NAME:_____

BIRTHDATE:_____ **RELATIONSHIP:**_____

SOCIAL SECURITY #:_____ - ____ - _____

REFERRING DR:_____ **CITY:**_____ **ST:**_____

I authorize any and all insurance benefits to which I am entitled for services rendered by The Retina Center, P.A. to be paid directly to The Retina Center, P.A.. I agree it is my responsibility to pay charges not covered by my insurance. I authorize any holder of medical or other information about me to release to the Social Security Administration, HCFA and its subsidiaries, and other insurance carriers or health care providers, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in the place of the original.

SIGNATURE:_____ **DATE:**_____

Name: _____
Referring Eye Care Provider: _____
DOB: _____ Height: _____ Weight: _____
Primary Medical Physician: _____
Pharmacy: _____

Eye History

1. What specific eye problems or visual difficulties are you experiencing now?

_____

_____

2. Do you or a blood relative have any of the following eye diseases: **please circle Yes or No**	**You**	**Family Member** (Specify relation) **please circle Yes or No**
Glaucoma	Yes No	Yes No
Cataracts	Yes No	Yes No
"Lazy eye" or muscle imbalance	Yes No	Yes No
Retinal disease	Yes No	Yes No
Macular degeneration	Yes No	Yes No
Other Problems		

3. Have you had any eye surgery, laser treatment to the eye, or eye injury? Yes No
If yes, please explain:

_____

_____

4. What ***eye*** medications are you using at present? Give name(s) , dosage, and how often taken:

_____

5. Do you wear glasses? Yes No
6. Do you wear contacts? Yes No If yes, what brand and power:

_____

7. When was your last eye exam?_____
   Who was your previous eye doctor?_____

Medical History please circle yes or no

8. Do you have now, or have you had:		If yes, explain date,duration & treatment
Diabetes Mellitus		Yes No
Heart attack		Yes No
Angina or chest pain		Yes No
Irregular or rapid heart beat		Yes No
Heart failure		Yes No
Cardiac pacemaker inserted		Yes No
High blood pressure		Yes No
High cholesterol		Yes No
A stroke or "shock"		Yes No
Anemia		Yes No
Emphysema or bronchitis		Yes No
Asthma		Yes No
Stomach or duodenal ulcer		Yes No
Arthritis	Yes No	If yes, list type

9.Are you allergic to any medication or foods? Yes No
Iodine/Shellfish
If yes, please describe substance, with date of reaction and type reaction: _____

10.Have you ever been diagnosed with cancer?
If yes, please indicate type and date-

_____

_____