RETINA CONSULTANTS LLC
2450 12th St. S.E.
Salem, Oregon 97302
503-371-4350

PATIENT REGISTRATION

Patient Name: _____ Nickname: _____
Last First Middle

Social Security #:_____ Date of Birth: _____ / _____ /_____

Birth Sex: Male ❑ Female ❑ Gender Identity: Male ❑ Female ❑ Other _____

Billing Address: _____

Name of Retirement home or Care Facility _____ Phone: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

I would like to receive a text message appointment reminder: YES ❑ NO ❑

Emergency Contact: _____ Relationship: _____ Phone: _____
Last First

Race: African American/ Black ❑ Asian ❑ Caucasian ❑ Hispanic/Latino ❑ Other: _____

Preferred Language: _____ I need an interpreter: YES ❑ NO ❑

Marital Status: _____ Student: YES ❑ NO ❑ Veteran: YES ❑ NO ❑ Smoker: YES ❑ NO ❑

Primary Care Physician: _____
Last First Clinic

Email address to sign up for the Patient Portal: _____ I decline ❑

Health Insurance

1. Insurance Company_____

   Policy or ID Number_____ Group Number_____

   Insured's Name_____ Relationship_____

   Insured Employer_____ Date of Birth _____ / _____ /_____

2. Insurance Company_____

   Policy or ID Number_____ Group Number_____

   Insured's Name_____ Relationship_____

   Insured Employer_____ Date of Birth _____ / _____ /_____

CONSENT FOR TREATMENT / RELEASE OF BENEFITS & INFORMATION

This signature authorizes consent for medical treatment & all insurance benefits to be paid directly to Retina Consultants, LLC. I certify that the insurance information I have reported is correct. Furthermore,I agree that I am responsible to report any changes in my insurance and take full responsibility for any residual balance due. I authorize the Doctor or the insurance company to release such information as necessary to facilitate payment of insurance benefits.

X_____ _____
Signature of Patient or Person Authorized Date of Signature

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I authorize Retina Consultants, LLC to use and disclose the health and medical information of

_____ for the following purposes:
Patient Name

Treatment

(Includes activities performed by a physician or other health care provider directly delivering care to you, coordinating or managing care provided to you with third parties, and consultations with and between physicians and other health care providers.)

Payment

(Includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities, including review of health care services for medical necessity, justification of charges pre-certification and pre-authorization of services.)

Health Care Operations

(Includes the necessary administrative and business functions of your health care provider.)

You may review our ***Notice of Privacy Practices*** for additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the ***Notice*** may change also. We will post a summarized copy of the ***Notice*** in the lobby of our office. We will provide you with a copy of the ***Notice*** upon your request.

As more fully explained in the ***Notice***, you have the right to request restrictions on how we use and disclose your health information. ***We are not required by law to agree to your request.***

_____ _____ OR
Date Signature of Patient

_____ _____
Date Signature of Person Authorized by Law

List of persons who you authorize to obtain health information on your behalf:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name _____ Date _____

REVIEW OF SYSTEMS (ROS) FORM

PLEASE CHECK ANY SYMPTOMS OR ISSUES THAT ARE CHRONIC OR PERSISTENT.
CHECK NONE IF NOTHING IN THE CATEGORY APPLIES.

Constitutional:

- ❑ Fatigue
- ❑ Fever
- ❑ Night Sweats
- ❑ Overall weakness
- ❑ Weight gain
- ❑ Weight loss
- ❑ None

HEENT:

- ❑ Hearing loss
- ❑ Sinus problems
- ❑ Sore throat
- ❑ Ringing in the ears (tinnitus)
- ❑ None

Respiratory:

- ❑ Cough
- ❑ Shortness of breath (dyspnea)
- ❑ Shortness of breath (dyspnea) while exercising
- ❑ Blood in sputum (hemoptysis)
- ❑ Wheezing
- ❑ None

Cardiovascular:

- ❑ Chest pressure or discomfort
- ❑ Irregular heartbeat / palpitations
- ❑ Leg swelling
- ❑ Racing heartbeat (tachycardia)
- ❑ None

Gastrointestinal:

- ❑ Abdominal pain
- ❑ Constipation
- ❑ Decreased appetite
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Nausea
- ❑ None

Genitourinary:

- ❑ Difficulty urinating (dysuria)
- ❑ Blood in urine (hematuria)
- ❑ Urgency
- ❑ None

Metabolic / Endocrine:

- ❑ Cold intolerance
- ❑ Heat intolerance
- ❑ Excessive thirst (polydipsia)
- ❑ None

Neurological:

- ❑ Balance problems
- ❑ Dizziness
- ❑ Headaches
- ❑ Memory Loss
- ❑ Numbness in arms or legs
- ❑ None

Psychiatric:

- ❑ Depression
- ❑ Insomnia
- ❑ Nervousness
- ❑ Stress
- ❑ None

Musculoskeletal:

- ❑ Back pain
- ❑ Joint stiffness
- ❑ Joint swelling
- ❑ Muscle cramping
- ❑ Muscle weakness
- ❑ None

Hematologic / Lymphatic:

- ❑ Frequent bleeding
- ❑ Frequent bruising
- ❑ None

MEDICATION LIST

List **ALL ORAL, INHALED, NASAL, INJECTABLE AND TOPICAL MEDICATIONS** including prescription (pills, inhalers, topical creams, etc.); eye drops (ex. artificial tears, Visine, allergy drops, etc.); over-the-counter (ex. **aspirin**, Tylenol, Advil, saline spray, etc.); injections (ex. insulin, vitamin B12, allergy shots, etc.); vitamins (ex. vitamin A, vitamin C, etc.); minerals (ex. calcium, iron, etc.); herbal supplements (ex. glucosamine chondroitin, ginkgo biloba, garlic, etc.) and oxygen:

Name of Med	Dosage	# per day	Reason for use of medication

Name of your Pharmacy(s) and location:

_____

_____

_____

_____

Medication Allergies/sensitivities:	Medication reactions:

Name _____ **Date** _____

MEDICAL HISTORY FORM

Name _____ Date _____

Height: _____ Weight: _____ DOB: _____

Allergies to Medicine: _____ Iodine ❑ Tape ❑

Current Eye Problems(s): Please describe _____

_____

PAST EYE HISTORY: (check the eye conditions you currently have or had)

❑ Blocked Retinal Blood Vessel
❑ Cataracts
❑ **Diabetic Retinopathy**
❑ Dry Eyes
❑ Eye Infection(s)
❑ Eye Injury
❑ Floaters and/or Flashes of Lights ❑ Right Eye
❑ Floaters and/or Flashes of Lights ❑ Left Eye
❑ **Glaucoma**
❑ Lazy Eye
❑ Inherited Eye Problem
Name: _____
❑ **Macular Degeneration**
❑ Myopia
❑ Retinal Detachment
❑ Retinal Tear
❑ Other: _____

Eye Surgeries: (including cataract, laser surgery, intraocular injection drugs with most recent treatment dates)

❑ Right Eye / Date

_____

_____

❑ Left Eye / Date

_____

_____

SOCIAL HISTORY:

Do you smoke? ❑ No ❑ Yes If yes, how much? #_____ pack(s) per day for _____ years
Prior history of smoking? ❑ No ❑ Yes If yes, age stopped _____
Do you use chewing tobacco? ❑ No ❑ Yes
Do you use or have used recreational drugs? ❑ No ❑ Yes
Do you drink alcohol? ❑ No ❑ Yes If yes, how much? _____
Work status: ❑ Retired ❑ Disability ❑ Student ❑ Unemployed ❑ Employed as _____
Do you drive? ❑ No ❑ Yes
Do you live? ❑ Alone ❑ with Spouse ❑ with Relatives ❑ Retirement Facility ❑ Significant Other
❑ Other: _____

PLEASE TURN PAPER OVER AND FILL OUT OTHER SECTIONS ↰

MEDICAL PROBLEMS: (check the medical conditions you have)

- ❑ Alzheimer's
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood Clots. If yes, where?_____
- ❑ Cancer Type: _____
- ❑ **High Cholesterol** (elevated lipids)
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Dementia
- ❑ **Diabetes** ❑ **Type 1** ❑ **Type 2** for _____ years
  A1C: _____ Date _____
- ❑ GERD (Gastrointestinal Reflux Disease)
- ❑ Heart Disease (Atrial Fibrillation, Heart Valve Disease, Congestive Heart Disease)
- ❑ Hepatitis / Liver Disease
- ❑ **High Blood Pressure (Hypertension)**
- ❑ Kidney/Renal Disease
- ❑ Heart Attack (Myocardial Infarction)
- ❑ Sleep apnea treatment Yes___ No___
- ❑ Stroke (CVA)
- ❑ Seizure Disorder
- ❑ Thyroid Disease
- ❑ Ulcers
- ❑ Other: _____

1) Prior surgeries:

_____

_____

_____

2) Prior hospitalizations in past year:

_____

_____

_____

FAMILY HISTORY: (conditions that run in the family) ❑ Adopted ❑ Do Not Know

Condition	Mother	Father	Sibling (brother or sister)	Child (son or daughter)
Diabetes ❑ **Type 1** ❑ **Type 2**				
Gastrointestinal Disorders				
Glaucoma				
Heart Disease				
Hypertension (high blood pressure)				
Kidney Disease				
Macular Degeneration				
Respiratory Disease				
Stroke				
Other:				