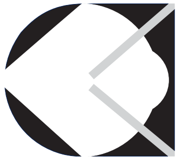


RETINA CONSULTANTS LLC
2450 12th St. S.E.
Salem, Oregon 97302
503-371-4350

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______________

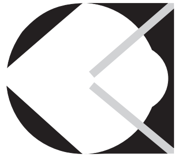
 Insured's Name______________ Relationship______________

 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:				

RETINA CONSULTANTS LLC
Physicians and Surgeons
Vitreo Retinal Consultation

What is Eye Dilation?

Eye dilation is a procedure where special eye drops are used to widen (dilate) the pupil. This allows the eye doctor to get a better view of the inside of the eye, including the lens, retina, and optic nerve.

What to Expect During Eye Dilation

- **Procedure**: The eye drops will be administered, and it takes about 15-30 minutes for your pupils to fully dilate.
- **Duration**: The effects of the dilation can last for several hours, typically between 4 to 8 hours, sometimes longer if a stronger dilation is required.

Possible Side Effects

1. **Light Sensitivity**: Your eyes will be more sensitive to light. Wearing sunglasses or after dilation glasses can help reduce discomfort and light sensitivity.
2. **Blurred Vision**: Your near vision will be blurred, which can make reading and other close-up tasks difficult.
3. **Difficulty Focusing**: You may find it hard to focus on objects that are close up.
4. **Stinging Sensation**: You might feel a mild stinging sensation when the drops are applied.
5. **Rare Reactions**: Although rare, some patients may experience an allergic reaction to the eye drops, which can cause redness, itching, or swelling, angle closure glaucoma attacks, and systemic reactions such as increased blood pressure, heart irregularity, dizziness, and increased sweating.

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996 NW Circle Blvd, Suite 101 Corvallis OR 97330 541-452-6001
www.salemretina.com

Safety and Precautions

- **Driving**: It is advisable not to drive or operate machinery until the effects of the dilation wear off due to the potential for blurred vision and increased light sensitivity.
- **Activities**: Avoid activities that require sharp vision or focus, such as reading or using digital devices, until your vision returns to normal, and walking may be more difficult with dilated eyes.

- **Protect Your Eyes**: Use sunglasses (or after dilation glasses, located at the front desk of our offices) to protect your eyes from bright light and glare when outdoors.

Aftercare

- **Normal Effects**: If your vision remains blurred or you continue to experience light sensitivity for more than 8 hours (1-2 days if a strong dilation is used, as is often done with lasers or surgical procedures), contact our office.
- **Emergency Symptoms**: If you experience severe pain, vision changes, or any other unusual symptoms, seek medical attention immediately.

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Vitreo Retinal Consultation

CONSENT for Eye Dilation

Dilating drops are an important component of your eye examination, whether for your initial consultation, diagnostics, procedures, and/or follow-up visits. These drops will dilate, or enlarge, your pupils, enabling your vitreoretinal doctor to obtain a clearer view of the back of your eye.

Dilating drops often cause temporary blurred vision, the duration of which varies among individuals. Additionally, they may increase sensitivity to bright lights. It is not possible for your ophthalmologist to predict the exact impact on your vision. **Consequently, driving may be challenging immediately following the examination. Therefore, it is advisable to arrange alternative transportation and avoid driving yourself.**

Adverse reaction, such as acute angle closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I, the undersigned, have read and understand the information handout provided to me regarding the eye dilation procedure and by signing this form, I voluntarily consent to undergo eye dilation @ Retina Consultants for this visit and any subsequent visit. I hereby authorize Retina Consultants (Dr. Westfall, Dr. Baynham, Dr. Michelotti, Dr. McClintic) and/or such assistants as may be designated by him/her to administer dilating eye drops.

Patient
Signature____________________________Date__________________________
(or person authorized to sign for patient)

Patient Name_________________________DOB_________________________

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