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 ❑

Billing Address: _____

Name of Retirement home or Care Facility _____ Phone: _____

Preferred contact method: Please check that all apply Cell ❑ Home ❑ Work ❑ Email ❑ Backup Method:

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

Email address to sign up for patient portal: _____ I decline ❑

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

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

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

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

Primary Care Physician: _____
Last First Clinic Location

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 Date of Birth

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 _____ DOB: _____ 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:

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

HEENT:

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

Respiratory:

- ❑ **None**
- ❑ Cough
- ❑ Shortness of breath (dyspnea)
- ❑ Shortness of breath (dyspnea) while exercising
- ❑ Wheezing

Cardiovascular:

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

Gastrointestinal:

- ❑ **None**
- ❑ Abdominal pain
- ❑ Constipation
- ❑ Loss of appetite
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Nausea

Genitourinary:

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

Metabolic / Endocrine:

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

Neurological:

- ❑ **None**
- ❑ Balance problems
- ❑ Dizziness
- ❑ Headaches
- ❑ Memory Loss
- ❑ Numbness in body

Psychiatric:

- ❑ **None**
- ❑ Depression
- ❑ Insomnia
- ❑ Nervousness

Musculoskeletal:

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

Hematologic / Lymphatic:

- ❑ **None**
- ❑ Frequent bleeding
- ❑ Frequent bruising

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 or have you used tobacco or nicotine (including smokeless and vapes)?

❑ Never smoked or used tobacco products ❑ Current every day smoker or tobacco user

❑ Current some day smoker or tobacco user ❑ Former smoker/tobacco user

Do you use or have used intravenous (IV) drugs? ❑ No ❑ Yes

Does your employment require you to operate a vehicle? ❑ No ❑ Yes If yes, vehicle type: _____

Do you live in a ❑ Nursing Home ❑ Retirement Facility

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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2815 SW Willetta, Suite A-2 Albany OR 97321 541-704-1003
3100 Haworth Ave, Suite 280 Newberg OR 97132 971-412-4278
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.

RETINA CONSULTANTS LLC
Physicians and Surgeons
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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