Today's date:	**Patient Information**	Patient account number:

Name:		Home phone:
Address:		Work phone:
City: State: Zip:		Cell phone:
Social Security #:	Gender: ☐Male ☐Female	Emergency contact name & phone:
Patient's date of birth:		2nd Emergency contact name & phone:
Referring doctor & location:		
Date of **last eye exam**:		

Who is financially responsible for this bill? ☐self ☐other: _____
Is your visit to our office related to a workman's compensation claim? ☐Yes ☐No
Is your visit to our office related to a motor vehicle accident? ☐Yes ☐No
Do you wish to authorize anyone else to obtain information about your care? ☐Yes ☐No
If yes, please list who:_____

Insurance	
Primary insurance company:	Policy holder's name:
Primary insurance Address:	Policy holder' date of birth:
Primary policy number:	Policy holder's employer:
Secondary insurance company:	Policy holder's name:
Secondary insurance Address:	Policy holder' date of birth:
Secondary policy number:	Policy holder's employer:
Medicare/Medicaid	
Medicare number:	Medicaid number:

Medicare Patients ONLY: Please check Yes or No. Questions 1-7				
	1	Do you or your spouse work for a company that provides you with health insurance?	☐Yes ☐No	7 Is Medicare your primary insurance? ☐Yes ☐No
	2	Are you entitled to Medicare because of disability or end stage renal disease?	☐Yes ☐No	
	3	Is this illness or injury the result of an automobile accident or other injury?	☐Yes ☐No	
	4	Is this illness or injury the result of an accident or illness that occurred at work?	☐Yes ☐No	
	5	Has treatment for this accident/illness been authorized by the veteran's administration?	☐Yes ☐No	
	6	Are you entitled to any benefits under the federal black lung program?	☐Yes ☐No	

ALL PATIENTS please Read and sign below:

I understand and agree that regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information. I authorize the doctor caring for me and his office to furnish my insurance company any medical information concerning myself necessary to provide insurance claims on my behalf.

I request that payment of authorized benefits be made on my behalf to the doctor caring for me for any services furnished to me by him. I authorize any holder of information about me in this office to release to Medicare or my insurance company and it's agents any information needed to determine these benefits payable for related services.

I have been offered the Retina Consultants of the Midlands notice of privacy practices form.

Signature _____ date _____

Today's date:	**Patient information (cont.)**	Name: _____ Date of Birth: _____

MEDICAL HISTORY QUESTIONNAIRE

Do you currently have or have you ever had any problems in the following areas?

Condition	Yes	No	Details
EYES (loss of vision, blur, glare, red, pain, etc.)			
GENERAL/CONSTITUTIONAL (fever, weight loss, etc.)			
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (heart attack or chest pain, high BP, racing pulse,			
RESPIRATORY (congestion, wheezing, etc.)			
GASTROINTESTINAL (stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (pimples, warts, growths, rash, breast, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, etc.)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)			
MUSCULOSKELETAL (muscle or joint pain)			
HEMATOLOGICAL/LYMPHATICS			

Please list all major illnesses, surgeries, or injuries and any past eye problems:	
Do any diseases run in your family (including eye diseases)?	☐No ☐Yes please explain:
Have you ever had a blood transfusion:	☐No ☐Yes
Have you recently been in contact with a person with a contagious disease:	☐No ☐Yes
Are you allergic to any medicines:	☐No ☐Yes please explain:
Are you allergic to latex:	☐No ☐Yes
Primary care medical doctor (not eye doctor):	**Primary care doctor's location:**

SOCIAL HISTORY

Are you: ☐Married ☐Single ☐Divorced ☐Widowed

Alcohol consumption: ☐never ☐ occasionally ☐ 1/day ☐ 2-3/day ☐ 4+/day

Tobacco: ☐never ☐yes usage _____

History of drug abuse: ☐Yes ☐No

_____ Reviewed by/Physicians Initials