AUSTIN RETINA ASSOCIATES PATIENT INFORMATION

NAME:
Last **First** **Middle Initial**

MAILING ADDRESS or NURSING HOME NAME & ADDRESS:

CITY: STATE: ZIP CODE: -
9 digit

TELEPHONE: HOME:( ) CELL: ( ) WORK:( )

DATE OF BIRTH: / / AGE: RACE:

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED GENDER: MALE FEMALE

DRIVERS LICENSE # STATE: **SS#:**

EMPLOYER: **OCCUPATION:**

ADDRESS: CITY: STATE: ZIP:

PARENT/EMERGENCY CONTACT: **PHONE: ( )** **CELL: ( )**

MEDICARE #: **MEDICAID #:**

HEALTH INSURANCE NAME:

ADDRESS: CITY: STATE: ZIP:

INSURED NAME: INSURED DATE OF BIRTH: / / INSURED SS#:

INSURED ID#: GROUP #: RELATIONSHIP TO PATIENT:

OTHER HEALTH INSURANCE NAME:

ADDRESS: CITY: STATE: ZIP:

INSURED NAME: INSURED DATE OF BIRTH: / / INSURED SS#:

INSURED ID#: GROUP #: RELATIONSHIP TO PATIENT:

REFERRING PHYSICIAN NAME: (first) **(last)**

ADDRESS: CITY: STATE: ZIP:

PRIMARY CARE PHYSICIAN NAME: (first) **(last)**

ADDRESS: CITY: STATE: ZIP:

I authorize any and all insurance benefits, to which I am entitled for services rendered by Austin Retina Associates, to be paid directly to Austin Retina Asscociates. 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 or other insurance claim. I permit a copy of this authorization to be used in place of the original. This authorization is in effect until I choose to revoke it.

SIGNATURE:_____DATE:_____/_____/_____

Name: Age:_____

Medical History: Please check all that apply.

Vision Problems

- ☐ headaches
- ☐ blank spots
- ☐ flashes
- ☐ floaters
- ☐ spots
- ☐ side vision loss
- ☐ night vision loss
- ☐ blurring
- ☐ double vision
- ☐ sudden loss
- ☐ pain
- ☐ curtain
- ☐ haze
- ☐ distortion

Trauma:_____ Other:_____

Eye Surgeries ☐ None

- ☐ Cataract/Implant ☐ R Eye when? _____ ☐ L Eye when? _____
- ☐ Glaucoma ☐ R Eye when? _____ ☐ L Eye when? _____
- ☐ Laser ☐ R Eye when? _____ ☐ L Eye when? _____
- ☐ Retina ☐ R Eye when? _____ ☐ L Eye when? _____

Other:_____

Illnesses and Conditions: ☐ None

- ☐ High Blood Pressure
- ☐ Heart Attack When:_____
- ☐ Stroke When:_____
- ☐ Cancer Type:_____
- ☐ Diabetes How Long:_____
- ☐ Arthritis
- ☐ Kidney Disease
- ☐ Vascular Disease
- ☐ HIV
- ☐ Heart Disease
- ☐ Asthma

Other:_____

Other Surgeries ☐ None

- ☐ Appendix
- ☐ Hysterectomy
- ☐ Prostate
- ☐ Gallbladder
- ☐ Heart…..type?_____
- ☐ Cancer…type?_____

Other:_____

Social History

- ☐ Drink alcohol
- ☐ Smoke now
- ☐ Smoke in the past
- ☐ Use street drugs

Other:_____

Allergies ☐ **None**

- ☐ Penicillin
- ☐ Codeine
- ☐ Sulfa
- ☐ Iodine
- ☐ Shell Fish

Other:_____

Family History ☐ **None**

- ☐ Diabetes
- ☐ Cataract
- ☐ Glaucoma

Other:_____

Please list medications including nonprescription drugs:_____

Signature:_____ **Date:**_____

Review of Systems NAME_____ DATE_____

1) Constitutional	Fever	□ yes □ no		
	Weight loss	□ yes □ no		
	Other	□ yes □ no		
2) Eyes	Blurred vision	□ yes □ no	Discharge	□ yes □ no
	Double vision	□ yes □ no	Other	□ yes □ no
	Pain	□ yes □ no		
3) Ears, Nose, Mouth, Throat				
	Pain	□ yes □ no	Hearing loss	□ yes □ no
	Mass	□ yes □ no	Smell	□ yes □ no
	Discharge	□ yes □ no	Other	□ yes □ no
4) Cardiovascular	Chest pain	□ yes □ no		
	SOB on exertion	□ yes □ no		
	Irregular heart beat	□ yes □ no		
	Other	□ yes □ no		
5) Respiratory	Short of breath	□ yes □ no	Asthma	□ yes □ no
	Cough	□ yes □ no	Other	□ yes □ no
6) Gastrointestinal	Bowel habits/change	□ yes □ no	Stomach pain	□ yes □ no
	Diarrhea	□ yes □ no	Ulcers	□ yes □ no
	Constipation	□ yes □ no	Other	□ yes □ no
7) Hematologic /Lymphatic				
	Anemia	□ yes □ no		
	Blood disease	□ yes □ no		
	Free bleeder	□ yes □ no		
	Swollen lymph nodes	□ yes □ no		
	Other	□ yes □ no		
8) Musculoskeletal	Weakness	□ yes □ no		
	Joint pain	□ yes □ no		
	Decreased ROM	□ yes □ no		
	Other	□ yes □ no		
9) Integument (Skin/Breast)				
	Masses	□ yes □ no	Rash	□ yes □ no
	Tumors	□ yes □ no	Other	□ yes □ no
	Pigmented lesions	□ yes □ no		
10) Neurologic	Weakness	□ yes □ no	Numbness	□ yes □ no
	Tingling	□ yes □ no	Other	□ yes □ no

Patient Signature_____

Austin Retina Associates
Written Acknowledgement Form

Our Notice of Privacy Practice provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy.

I_____(Please print patient name) have been provided a copy of Austin Retina's Notice of Health Information Practices.

I have had an opportunity to read the Notice of Health Information Practices.

I understand that I may ask questions of the Privacy Officer if I do not understand any information contained in the Notice of Health Information Practices.

_____
Patient Signature

_____
Date

_____
Authorized Representative of Patient

_____
Relationship to Patient

Austin Retina Associates
Authorization to Release Medical Information

I_____authorize Austin Retina Associates to release all medical information including test results and future appointment dates and/or times to the following friends or relatives: (please print)

1._____

2._____

3._____

Please check all that apply where we may leave a message for you.

____Your answering machine

____At your place of employment

Other_____

May we send you a postcard regarding appointments?
___Yes ___No

_____ _____
Patient/Guardian Signature Date