AUSTIN RETINA ASSOCIATES PATIENT INFORMATION

NAME: _____
Last First Middle Initial

MAILING ADDRESS or NURSING HOME NAME & ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____ - _____

TELEPHONE: HOME / CELL/ WORK ( ) _____ **EMAIL :** _____

DATE OF BIRTH: ___/___/___ **AGE:** _____ **RACE:** _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED **GENDER: MALE FEMALE**

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

EMPLOYER: _____ **OCCUPATION:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

SPOUSE / PARENT / GUARDIAN NAME: _____ **EMPLOYER:** _____
Circle One:

EMERGENCY CONTACT: _____ **PHONE:( )** _____ **CELL: ( )** _____

MEDICARE #: _____ **MEDICAID #:** _____

HEALTH INSURANCE NAME: _____

INSURED NAME: _____ **INSURED DATE OF BIRTH:** ___/___/___

INSURED ID#: _____ **GROUP #:** _____ **RELATIONSHIP TO PATIENT:** _____

OTHER HEALTH INSURANCE NAME: _____

INSURED NAME: _____ **INSURED DATE OF BIRTH:** ___/___/___

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 Associates. 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:** ___/___/___

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_____

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:** _____

AUSTIN RETINA
ASSOCIATES
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Diplomates American Board of Ophthalmology

Please indicate if you have given someone other than yourself medical Power Of Attorney or if someone is your legal guardian.

- ❑ I am my own Power of Attorney
- ❑ I have assigned another individual as my Power of Attorney

If applicable, please fill out the following:

Name of Power of Attorney: _____

Relationship to Patient: _____

Phone number to contact POA: _____

In addition, please provide Austin Retina with a copy of the signed POA document stating who can exercise your rights and make choices about your health information.

_____

Patient Name

_____ _____

Patient Signature Date