CHARLES RETINA INSTITUTE

PATIENT REGISTRATION

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Date of Birth: _____ **Sex:** ○ **Female** ○ **Male** **Marital Status:** ○ **Single** ○ **Married** ○ **Widowed**

Race/ Ethnic Group: _____ **Social Security Number**_____-_____-_____

Address:_____

Home Phone: _____ **Cell Phone:**_____ **Work Phone:** _____

Do we have your authorization to leave information on your voicemail? ○ **Yes** ○ **No**

Email Address:_____ **Occupation**_____

Emergency Contacts:

Name:_____ **Phone :**_____ **Relation:** _____

Name:_____ **Phone:**_____ **Relation:**_____

Medical Insurance:

○ **Medical** ○ **Veterans Administration** ○ **Church Health** ○ **Workman's Comp** ○ **Uninsured**

Primary Medical Insurance: _____ **Secondary Medical Insurance**_____

Member ID:_____ **Member ID:**_____

Policy Holders Name:_____ **Policy Holders Name:**_____

Policy Holders DOB:_____ **Policy Holders DOB:**_____

Responsible Party (If someone other than yourself is responsible for payment)_____

Medical Doctors:

Name of Referring Doctor_____ **Name of Medical Doctor**_____

Name of Diabetic Doctor_____ **Any other Eye Doctor**_____

Pharmacy:

Pharmacy Name: _____ **Pharmacy Phone:**_____

Pharmacy Address: _____

Notice of Privacy Practices:

The Charles Retina Institute is fully compliant with the requirements of the Health Insurance Probability and Accountability Act of 1996 (HIPPA) allows CRI to release my health information for the purposes of treatment, payment, or health care operations without obtaining my permission or authorization. All other releases of information will require my signature prior to CRI sending any documents. The official Notice of Privacy Practices for the Charles Retina Institute is posted in a conspicuous place in the office, and copy is available upon request.

Initial_____ I have been shown or offered a copy of Charles Retina Institute's statement on privacy policies that is displayed at the front desk and the lobby.

Authorization to Release Information:

Initial_____ I give my permission to Charles Retina Institute to release my information to the individuals below (Please list all names that apply *and* their relationship to you):

_____ _____

_____ _____

_____ _____

I understand that this authorization will be maintained in my medical record. I have the right to update this authorization at any time by submitting a request in writing by me.

Patient Signature:_____ **Date**_____

Signature on File Authorization:

I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductibles, co-pay, or any other balance not paid by my insurance company. Balances are due within 30 days of filing date. Payment for non-covered services is also due once services are rendered.

Patient Signature:_____ **Date**_____

I hereby authorize Charles Retina Institute to release any medical or incidental information that may be necessary for medical benefit in processing applications for financial benefit. This includes, but is not limited to, my insurance company, rehabilitation services, social security administration, and worker's compensation.

Patient Signature:_____ **Date**_____

COMPLETE this form entirely and give it to the receptionist at the front desk or mail the forms to our office.

Please be sure to bring Insurance cards, photo ID, and a list of medications to your appointment.

CHARLES RETINA INSTITUTE

PATIENT HEALTH HISTORY

Name:_____ Date of Birth:_____ Today's Date:_____

Please check the appropriate and answer all questions on both front and back of this form.

Have you ever been diagnosed with:

☐ Yes ☐ No Diabetes
Type 1 Type 2
Since _____
Last A1C _____

☐ Yes ☐ No Kidney Failure
Are you currently on Dialysis? ☐ Yes ☐ No

☐ Yes ☐ No Arthritis
☐ Yes ☐ No Rheumatoid Disease
☐ Yes ☐ No Blood Disorders
☐ Yes ☐ No Bone or Muscle Disease
☐ Yes ☐ No Cholesterol/Lipid Disorder
☐ Yes ☐ No Depression/Psychiatric Disorder
☐ Yes ☐ No Heart Disease
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No HIV/AIDS
☐ Yes ☐ No Hypertension/High Blood Pressure
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Lung Disease/Asthma
☐ Yes ☐ No Migraine Headaches
☐ Yes ☐ No Sarcoidosis
☐ Yes ☐ No Sickle Cell
☐ Yes ☐ No Stomach or Digestive Disease/Ulcers
☐ Yes ☐ No Systemic Lupus
☐ Yes ☐ No Thyroid Disease
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Cancer Type_____

Have you had any of the following:

☐ Yes ☐ No Head/Neck/Back Injury
☐ Yes ☐ No Stroke
☐ Yes ☐ No Permanent Defect from Illness or Injury
☐ Yes ☐ No Extensive Confinement from Illness or Injury
☐ Yes ☐ No Heart Attack
☐ Yes ☐ No Recent Weightloss
☐ Yes ☐ No Recent High Fever
☐ Yes ☐ No Recent Hospitalization, If Yes, for what condition?

_____
_____

Are you currently experiencing any of the following:

☐ Yes ☐ No Chest Pain
☐ Yes ☐ No Severe Headaches
☐ Yes ☐ No Seizures/Convulsions
☐ Yes ☐ No Fainting
☐ Yes ☐ No Severe Coughing
☐ Yes ☐ No Dizziness
☐ Yes ☐ No Seasonal Allergies

Are You:

☐ Yes ☐ No Pregnant
☐ Yes ☐ No Hearing Impaired
☐ Yes ☐ No A Past Smoker

Do You:

☐ Yes ☐ No Smoke
☐ Yes ☐ No Drink Alcohol
☐ Yes ☐ No Live Alone

Please list any other medical conditions:

_____
_____
_____

Are you Allergic to any of the following:

☐ Yes ☐ No Penicillin
☐ Yes ☐ No Codeine
☐ Yes ☐ No Sulfa
☐ Yes ☐ No Latex

List any other known allergies:

_____ _____
_____ _____
_____ _____

Family History

Has any member(s) of your primary/close blood relatives had any of the following:
Please check the box for each condition that applies and indicate the relation.

☐ Yes ☐ No Diabetes Relation_____
☐ Yes ☐ No Heart Disease Relation_____
☐ Yes ☐ No Stoke Relation_____
☐ Yes ☐ No Retinitis Pigmentosa Relation_____
☐ Yes ☐ No Retinal Detachments Relation_____
☐ Yes ☐ No Macular Degeneration Relation_____
☐ Yes ☐ No Glaucoma Relation_____
☐ Yes ☐ No Cancer Relation_____

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PATIENT HEALTH HISTORY

Eye History

Do you or have you had any of the following:

☐ Yes ☐ No Crossed Eyes
☐ Yes ☐ No Lazy Eyes
☐ Yes ☐ No Eye Inflammation
☐ Yes ☐ No Eye Infection/Pink Eye
☐ Yes ☐ No Eye Injury
☐ Yes ☐ No Retina Disease

Refractive Surgery ☐ No ☐ Yes
☐ Right Eye
Year:_____ By Doctor: _____
☐ Left Eye
Year:_____ By Doctor: _____

Retina/Vitreous Surgery ☐ No ☐ Yes
☐ Right Eye
Year:_____ By Doctor: _____
☐ Left Eye
Year:_____ By Doctor: _____

☐ Yes ☐ No Cataracts
Have you had cataract surgery? ☐ No ☐ Yes
☐ Right Eye Year:_____ By Doctor: _____
☐ Left Eye Year:_____ By Doctor: _____

☐ Yes ☐ No Glaucoma
Have you had glaucoma surgery? ☐ No ☐ Yes
☐ Right Eye Year:_____ By Doctor: _____
☐ Left Eye Year:_____ By Doctor: _____

List any other Eye conditions or surgeries:

_____ _____
_____ _____
_____ _____

Medication Lists:

List all current Eye medications:

_____
_____
_____
_____
_____
_____
_____

List all other current medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____