Livingston Vitreo Retinal Associates

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PATIENT INFORMATION

NAME (LAST, FIRST)	MRN	SS#	SEX	BIRTHDATE

STREET ADDRESS	CITY, STATE, ZIP	HOME PHONE

LANGUAGE	SMOKER (Y/N)	ETHNICITY	EMAIL ADDRESS	RACE

MARITAL STATUS	STUDENT STATUS	CELL PHONE	WORK PHONE

REFRRING DOCTOR NAME AND ADDRESS	PHONE #

PRIMARY CARE PHYSICIAN NAME AND ADDRESS	PHONE #

RESPONSIBLE PARTY INFORMATION (if different than above)

NAME	RELATION	PHONE

STREET ADDRESS	CITY, STATE, ZIP

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY #
NAME OF INSURED	GROUP #

INSURED D.O.B	INSURED S.S #	COPAY AMMOUNT
		$

ADDRESS OF INSURANCE COMPANY	DEDUCTIBLE

CITY, STATE, ZIP	PHONE	

RELATIONSHIP TO PATIENT

SECONDARY INSURANCE (if applicable)

NAME OF INSURANCE COMPANY	POLICY #
NAME OF INSURED	GROUP #

INSURED D.O.B	INSURED S.S #	COPAY AMMOUNT
		$

ADDRESS OF INSURANCE COMPANY	DEDUCTIBLE
	$

CITY, STATE, ZIP	PHONE	

RELATIONSHIP TO PATIENT

EMERGENCY CONTACT

NAME	PHONE

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT ANY INTEREST of 1.5% and a $15.00 collection fee MAY BE CHARGED on all balances owed to the provider that are past

Signature ______________________________
(signature of insured or authorized person, patient, or parent if minor)

Date: ____/____/____

Medical History

Patient Name: ______________________________ Today's Date__________

Reason for todays visit: ____

Onset of symptoms: ______________________________

Do you wear glasses? YES NO **Circle One** (Near, far, bifocal)

Medications (including eye drops, vitamins, herbs and over the counter meds including Aspirin & pain relievers):

Name	Dose	Frequency

Medication Allergies:

Drug	Reaction

Environmental Allergies:	**Reaction**

Past Ocular History and Surgeries:

Condition			Date Diagnosed	Treatment	Eye
Glaucoma	YES	NO			
Macular Degeneration	YES	NO			
Diabetic Eye Disease	YES	NO			
Retinal Detachment	YES	NO			
Cataracts	YES	NO			

Please list any additional ocular conditions below:

Diabetes Type I.................................. YES NO Date of onset: ________________

Last Blood Sugar:________

Last A1C:________ Date: ________

Diabetes Type II................................. YES NO Date of onset:________________

Last Blood Sugar:________

Last A1C:________ Date: ________

Medical History:

Diagnosis			**Year**	**Treatment**	**When**
Thyroid Disease	YES	NO			
Palpitations	YES	NO			
High Blood Pressure	YES	NO			
Heart Attack	YES	NO			
Pacemaker	YES	NO			
Carotid Artery Disease	YES	NO			
Angioplasty/Bipass	YES	NO			
Elevated Cholesterol	YES	NO			
Anemia	YES	NO			
Sickle Cell	YES	NO			
Immune Deficiency	YES	NO			
Lupus	YES	NO			
HIV/AIDS	YES	NO			
Sarcoidosis	YES	NO			
Hepatitis	YES	NO		Type:	
Gallbladder	YES	NO			
Inflammatory Bowel	YES	NO			
Stroke	YES	NO			
Seizures	YES	NO			
Multiple Sclerosis	YES	NO			
Headaches	YES	NO			
Prostate Disease	YES	NO			
Renal Failure	YES	NO			
Rheumatoid Arthritis	YES	NO			
Dementia	YES	NO			
Alzheimer's	YES	NO			
Depression	YES	NO			
Cancer	YES	NO		Type:	
Asthma	YES	NO			
Emphysema	YES	NO			
Tuberculosis	YES	NO			

Please list any additional conditions and surgeries below:

Family History:

			Relation
Amblyopia	YES	NO	
Blindness	YES	NO	
Diabetic Eye	YES	NO	
Cataracts	YES	NO	
Glaucoma	YES	NO	
Macular Degeneration	YES	NO	
Retinal Detachment	YES	NO	
Retinal Disorders	YES	NO	
Sickle Cell	YES	NO	
Strabismus	YES	NO	

Have **YOU** had any:

Eye surgery	YES	NO	Galucoma	YES	NO
Laser treatments	YES	NO	Decrease in vision	YES	NO
Eye Prescriptions	YES	NO	Floaters	YES	NO
Eye Trauma	YES	NO	Flashes	YES	NO
Corrective glasses	YES	NO			

Social History:

Do you smoke? YES NO How Long? ___________ When did you quit?

Alcohol Use: YES NO How Much? ___________________

Recreational drug use: YES NO

Do you use caffeine: YES NO How much caffeine do you consume per day? ___________________

List all Physicians:

Name & Specialty	Address:	Phone & Fax #'s

Can we contact your pharmacy for a complete list of your medication? YES NO

Pharmacy, Address & Phone#: ____

____

Reviewed with patient: ______________________________ Date: ________________

RETINA-VITREOUS CONSULTANTS
LIVINGSTON VITREO-RETINAL ASSOCIATES

I understand that professional services are rendered to the patient and that patient is responsible for the charges incurred. I understand that I am financially responsible for the charges not covered by my insurance company. I understand that the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I understand that any balance left unpaid will be subject to an interest rate of 1.5% monthly and a $15.00 Collection Fee.

Signature ___________________________

I understand that I will be charged a $30.00 fee for any returned checks.

Initial_________

I voluntarily consent to necessary care and treatment as prescribed by the physician.

Initial_________

I acknowledge that I have received a copy of Retina-Vitreous Consultants Privacy Act.

Initial_________

I hereby authorize the following people to have full access to my medical information and records:

____

____

____

I hereby give permission for the office to contact the following people regarding any financial questions that may arise during the course of my treatment:

____

____

____

By my signature below, I acknowledge that I have received Retina-Vitreous Consultants/Livingston Vitreo-Retinal Assoc. Notice of Privacy Practices and I authorize the release of my private healthcare information for the purposes of treatment, payment and healthcare operations as indicated within.

____

Name (print)

____

Signature

____

Date