

**PATIENT REGISTRATION**

Please print clearly.

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ INITIAL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_

CELL PHONE: (\_\_\_\_) \_\_\_\_\_ EMAIL: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ MALE FEMALE

RACE: \_\_\_\_\_ ETHNICITY: HISPANIC NOT HISPANIC DECLINED TO SPECIFY

SOCIAL SECURITY NUMBER: \_\_\_\_\_

WORK STATUS: PART-TIME FULL-TIME RETIRED FULL-TIME STUDENT

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

SPOUSE'S NAME: \_\_\_\_\_ DAY PHONE: \_\_\_\_\_

**REFERRAL INFORMATION**

REFERRING PHYSICIAN: \_\_\_\_\_

Specialty: (circle one) Ophthalmologist Optometrist Internist Family Practitioner

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

FAX: (\_\_\_\_) \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

FAX: (\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION** *Please present your insurance card to the receptionist*

\*If an insurance card is not presented the balance will be transferred to the patient.

**EMERGENCY CONTACT:** \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ DAY PHONE: \_\_\_\_\_

IF YOUR ILLNESS OR INJURY IS WORK RELATED, please provide:

DATE OF INJURY: \_\_\_\_\_

WORK COMP INFO: \_\_\_\_\_ PHONE: \_\_\_\_\_

**BENEFITS AND MEDICAL RELEASE AUTHORIZATION**

*Insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a substitute for payment. It is your responsibility to pay any deductible, co-payment or any balance not paid for by your insurance.*

I hereby authorize payment of Medicare or other insurance benefits available for medical or surgical services to South Coast Retina Center.

I authorize the release of any medical information requested by my insurance company concerning my illness, surgery or injury.

I authorize South Coast Retina Center to utilize an online platform in order to transmit and receive medication prescription requests, also known as e-prescribing.

**I understand that if I am a member of a Health Maintenance Organization (HMO)** and if prior authorization is not obtained, I may be responsible for the charges incurred on that particular date of treatment. I understand that all co-payments are due at the time of the visit or procedure.

PATIENT NAME: \_\_\_\_\_  
(Please print)

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

**ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES**

**I hereby acknowledge that I have been offered a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be located in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.**

**The Notice of Privacy Practices will be offered to me at my first office visit.**

\_\_\_\_\_  
**Signed**

\_\_\_\_\_  
**Date**

**Print Name:** \_\_\_\_\_

# Medical History Questionnaire

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_

Date of birth \_\_\_\_\_ Date of last eye exam \_\_\_\_\_

Referring Dr. \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

What is the chief complaint regarding your eyes? \_\_\_\_\_

List any medications you currently take (prescription and over-the-counter), including ocular drops and vitamins:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Pharmacy Name:** \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have allergies to any medications?  YES  NO If YES, list the medications and your allergic reaction to them: \_\_\_\_\_

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.)

List any surgeries you have had (cataract, tonsils, appendix, etc.) \_\_\_\_\_

Do you currently have any of the problems below? If YES please give details:

EYES	RIGHT	LEFT	NO	EXPLANATION OF PROBLEM
Loss of vision				
Distorted vision				
Loss of side vision				
Double vision				
Itching				
Tearing/watering				
Pain				
Crossed or lazy eye				
Drooping eyelid				
Cataract				
Glaucoma				
Flashes				
Floaters				
Retinal Tear				
Retinal detachment				
Retinal laser				
Eye trauma				

	YES	NO	EXPLANATION OF PROBLEM
<b>GENERAL/CONSTITUTIONAL (Fever)</b>			
(Weight loss)			
<b>EARS, NOSE, THROAT (Sinus infections)</b>			
(ear infection, chronic cough, dry mouth)			
<b>CARDIOVASCULAR (Heart Attack)</b>			
(High blood pressure)			
<b>RESPIRATORY (Asthma)</b>			
(Emphysema)			
<b>GASTROINTESTINAL (Stomach ulcers)</b>			
(Hepatitis)			
<b>GENITAL, KIDNEY (Kidney stones)</b>			
(Dialysis)			
<b>MUSCLES, BONES, JOINTS (Arthritis)</b>			
(Polymyalgia rheumatica)			
<b>SKIN (Acne, warts, Vitiligo)</b>			
<b>NEUROLOGICAL (Stroke)</b>			
(Multiple sclerosis)			
<b>ENDOCRINE (thyroid)</b>			
Diabetes [how long?]			
<b>BLOOD/LYMPH (Cholesterol, anemia)</b>			
(Taking blood thinners)			
<b>INFECTIOUS DISEASE (Syphilis, TB, HIV)</b>			
<b>ALLERGIC/IMMUNOLOGIC (Lupus, Sjogrens)</b>			
<b>CANCER</b>			

## FAMILY HISTORY

M=Mother, F=Father, S=Sibling, GP=Grandparents

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Retinal Detachment			
Macular Degeneration			
Glaucoma			
Cancer			
Diabetes			

## SOCIAL HISTORY

Current or prior occupation: \_\_\_\_\_

Education (high school, vocational school, college degree): \_\_\_\_\_

Marital Status (married, divorced, single, widowed): \_\_\_\_\_

Living Arrangements: \_\_\_\_\_

Do you drive?  YES  NO

Do you have visual difficulty when driving?  YES  NO

Do you have problems with night vision?  YES  NO

Do you drink alcohol?  YES  NO If YES: occasional 1 per day 2-3/day 4+/day

Do you smoke?  YES  NO If YES: occasional 1 per day 2-3/day 4+/day

Do you have a history of substance use/abuse?  YES  NO If YES: \_\_\_\_\_

Have you ever had a blood transfusion?  YES  NO