Date_____ Patient Name_____

Last Name First Name Middle Initial

Circle: Male / Female Married / Widow / Single / Child

Date of Birth_____ Age_____ Social Security Number_____

Preferred Language_____

Ethnicity __Hispanic or Latino
__Not Hispanic or Latino
__Unknown
__Decline to Specify

Race __American Indian or Alaska Native
__Asian
__Black or African American
__White
__Other Race
__Decline to Specify

Address_____

City/State/Zip_____

Home (____)_____ Work (____)_____ Cell (____)_____

Email address_____

Preferred method of contact TEXT / EMAIL / CALL

Employer/School_____ Occupation_____

Emergency Contact Name_____

Relationship to Patient_____

Home (____)_____ Work (____)_____ Cell (____)_____

Check here if uninsured_____

Primary Insurance Company_____

Subscribers Name/Relationship to patient_____

Secondary Insurance Company_____

Subscribers Name/Relationship to patient_____

Check here if you are not under a Primary Care Physician's Care_____

Primary Care Physician _____ Phone Number_____

Eye Care Physician_____ Phone Number_____

Pharmacy Name and Location_____

Pharmacy Phone Number_____

Retina Consultants of Charleston

FINANCIAL POLICY

Each patient is responsible for his or her own bill. I hereby authorize Retina Consultants of Charleston to release to my insurance company any information acquired during my examination or treatment.

Payment of all insurance co-payments and/or deductibles are due at the time medical services are rendered. Patients who have no insurance are required to pay 100% of services rendered at each visit. If this is impossible, you will need to make payment arrangements with our office prior to any medical evaluation for treatment. We accept cash, checks and major credit cards.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing you must provide all insurance policy information including any changes in coverage to this office. Your bill is your responsibility whether your insurance company pays or not. At times you may need to contact your insurance carrier regarding slow or nonpayment of your insurance claim.

You are responsible for knowing what your insurance covers, your current copay amount and the provider(s)/network(s) covered under your health insurance plan. Any service provided but not covered by your insurance company will be your responsibility to pay.

If your insurance company has not paid your full account within 60 days, you must pay the outstanding balance without further delay.

A 35.00 fee will be charged on all returned checks.

I understand that this is a binding agreement between myself and Retina Consultants. I understand that I will be held responsible for any outstanding balances.

X_____

Signature of patient (Parent/Legal Guardian if a minor) Date

X_____

Witness Date

Patient Name_____ Date of Birth_____
Date of Last Eye Exam_____

List MEDICATIONS (RX and Over the Counter)

_____
_____
_____
_____

List all MAJOR ILLNESSES

_____
_____
_____
_____

Are you allergic to any medications? YES NO
If YES, list the medications_____

_____
_____

List any SURGERIES you have had

_____
_____
_____

Do you CURRENTLY have any problems in the following area? Please circle any that apply and provide additional information in the details section. Check NO if you do not have any problems in a listed area.

EYES – Poor Vision, Eye Pain, Tearing, Redness, Other		
GENERAL CONSTITUTION Fever, Heat Stroke, Weight Loss, Weight Gain, Fatigue, Other		
EARS, NOSE, THROAT Hearing Loss, Nasal Congestion, Earache, Cough, Dry mouth, Other		
CARDIOVASCULAR High Blood Pressure, Racing Pulse, Other		
RESPIRATORY Congestion, Wheezing, Shortness of Breath, Other		
GASTROINTESTINAL Nausea, Diarrhea, Constipation, Hernia, Ulcers, Other		
GENITAL/KIDNEY/BLADDER Painful Urination, Frequent Urination, Impotence, Jaundice, Other		
FEMALES Pregnant /Nursing		
MUSCLES/BONES/JOINTS Joint Pain, Stiffness, Swelling, Cramps, Arthritis, Other		
SKIN Pimples, Warts, Growths, Rash, Other		
NEUROLOGICAL Numbness, Headaches, Seizures, Paralysis, Other		
PSYCHIATRIC Anxiety, Depression, Insomnia, Other		
ENDOCRINE Diabetes, Hypothyroid, Other		
BLOOD/LYMPH Bleeding, Cholesterolemia, Anemia, HIV/AIDS, Hepatitis, Other		
ALLERGIC/IMMUNOLOGIC Sneezing, Redness, Itching, Hives, Lupus, Other		

FAMILY HISTORY (Mother, Father, Sibling, Grandparent) Has any member of your family had these diseases (Circle all that apply) BLINDNESS / CATARACT / GLAUCOMA / DIABETES / HYPERTENSION / HEART DISEASE / STROKE / CANCER / THYROID DISEASE / ARTHRITIS other heritable disease_____

SOCIAL HISTORY

Does your Vision limit any activities of daily living (reading, driving, sports, work, etc) YES NO
Do you drink alcohol YES NO If yes how much_____
Do you smoke YES NO If yes how much_____ How many years_____