Account #_____

# Retina Consultants of Carolina, P.A.

*Specializing in diseases and injuries of the retina, vitreous and macula*

## Patient Demographic Form

**First:** _____ **Middle:** _____ **Last:** _____ **Date of Birth:**_____

**Have you been to our practice before:** ____**Yes** ____**No** **Last Date Seen:** _____

**Home Address:**

_____

_____

**Zip:** _____ **City:**_____ **State:**_____

**Mailing Address (If Different):**

_____

_____

**Zip:**_____ **City:**_____ **State:**_____

**Gender:** M or F **Home Phone:** _____**Daytime Number:** _____ **Cell:** _____

**SSN:** _____
(Your SSN is mandatory when scheduling anything at the hospital)

**Marital Status:** ___Single ___Married ____Divorced ___Widowed

**Do you live in a Skilled Nursing Facility for Rehabilitation?** ___Yes ___No **Facility Name:** _____

**Patient Employer Name:** _____ **Phone:** _____

**Employment Status:** ___Full Time ___Part Time ___Retired/Disabled **Referring Physician:** _____

**Language:** _____ **Race:** _____ **Email Address:** _____

**Guarantor Information for Minors (Under 18)**

Name: _____ Date of Birth: _____ SSN: _____

**Emergency Contact Information:**

Name: _____Relationship:_____Phone:_____

**Who is your Primary Care Physician?**

**Are you a Diabetic?** **Yes or No** **If yes, Who is your diabetic doctor?**

**Is your visit related to Workman's Compensation or a Work Related Injury?** Yes or No
**Date of Injury:** _____**Location of Injury:** _____Right Eye ____Left Eye
**Employer Contact Name:** _____ **Employer Contact Number:** _____

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# Retina Consultants of Carolina, P.A. Medical History Questionnaire

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: _____

**Eye Doctor:** _____ Address _____

*Date Last Seen:* _____ *Next Appointment:* _____

**Family Doctor:** _____ Address: _____

*Date Last Seen:* _____ *Next Appointment:* _____

**Diabetic Doctor (if applicable):** _____ Address: _____

*Date Last Seen:* _____ *Next Appointment:* _____

## History of Present Illness

What is the Main Problem that brings you here?

_____

_____

In Which eye? _____ For How Long? _____

## Ocular History

Did any previous eye disorder result in vision loss? No _____ Yes _____

If yes, please describe:

_____

_____

Have you had any eye diseases, surgery or injury? No _____ Yes _____
If yes, please describe:

_____

_____

Do you wear glasses or contacts? No _____ Yes _____
How old is your prescription?

_____

Any history of Amblyopia or "Lazy Eye"? No _____ Yes _____

## Past History

Have you had any serious medical problems? No _____ Yes _____

If yes, please describe

_____

_____

Were you born premature? No _____ Yes _____

Prior surgeries and hospitalizations (Please include dates)

_____

_____

Do you take aspirin or blood thinner on a regular basis? No _____ Yes _____

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# Retina Consultants of Carolina, P.A. Medical History Questionnaire

## Review of Symptoms

Please circle **YES** or **NO** to the below symptoms/problems.

**Constitutional:**

| | | | |
|---|---|---|---|
| Fever | YES | or | NO |
| Weight Loss | YES | or | NO |
| Night Sweats | YES | or | NO |

**Ear, Nose, Mouth, Throat:**

| | | | |
|---|---|---|---|
| Hearing Loss | YES | or | NO |
| Pain/Discharge | YES | or | NO |
| Dizziness/Fainting | YES | or | NO |
| Nose Bleeds | YES | or | NO |
| Ringing in Ears | YES | or | NO |
| Sinus Pain | YES | or | NO |

**Cardiovascular:**

| | | | |
|---|---|---|---|
| Chest Pain | YES | or | NO |
| Irregular Heart Beat | YES | or | NO |
| Shortness of Breath on Exertion | YES | or | NO |
| Swelling of Feet | YES | or | NO |
| High Blood Pressure | YES | or | NO |
| Heart Attack/Disease | YES | or | NO |
| Elevated Cholesterol/ Triglycerides | YES | or | NO |

**Respiratory:**

| | | | |
|---|---|---|---|
| Shortness of Breath | YES | or | NO |
| Cough | YES | or | NO |
| Asthma/Emphysema | YES | or | NO |
| Tuberculosis (TB) | YES | or | NO |

Other_____

**Gastrointestinal:**

| | | | |
|---|---|---|---|
| Change in Bowel Habits | YES | or | NO |
| Diarrhea | YES | or | NO |
| Constipation | YES | or | NO |
| Stomach Pain | YES | or | NO |
| Ulcers | YES | or | NO |

Other_____

**Endocrine:**

| | | | |
|---|---|---|---|
| Thyroid Disease | YES | or | NO |
| Diabetes | YES | or | NO |

**Musculoskeletal:**

| | | | |
|---|---|---|---|
| Pain/Swelling | YES | or | NO |
| Weakness | YES | or | NO |
| Lupus | YES | or | NO |
| Arthritis | YES | or | NO |

**Skin/Breast:**

| | | | |
|---|---|---|---|
| Masses | YES | or | NO |
| Tumors | YES | or | NO |

Other_____

**Neurologic:**

| | | | |
|---|---|---|---|
| Numbness/Tingling | YES | or | NO |
| Seizures/Epilepsy | YES | or | NO |
| Weakness in Arm/Leg | YES | or | NO |
| Lyme Disease | YES | or | NO |
| Alzheimer's disease | YES | or | NO |
| Parkinson's disease | YES | or | NO |
| Migraines | YES | or | NO |
| Stroke | YES | or | NO |

**Mood Disorders;**

| | | | |
|---|---|---|---|
| Anxious/Nervous | YES | or | NO |
| Depression | YES | or | NO |

Other_____

**Genitourinary:**

| | | | |
|---|---|---|---|
| Kidney Trouble | YES | or | NO |
| Urinary Problems | YES | or | NO |
| Venereal Disease | YES | or | NO |

**Hematologic:**

| | | | |
|---|---|---|---|
| Bleed/Bruise Easily | YES | or | NO |
| Anemia | YES | or | NO |
| Prior Blood Transfusion | YES | or | NO |
| Sickle Cell Disease | YES | or | NO |
| Hepatitis | YES | or | NO |
| HIV/AIDS and/or Exposure | YES | or | NO |

## DIABETICS:

Date Diagnosed:_____ How often do you see your diabetic doctor? _____

How often do you test your blood sugar? _____ What was your blood sugar when last tested? _____

When was your blood sugar last tested?_____ Your last Hemoglobin A1C_____

When was your Hemoglobin A1C last tested?_____

Have you ever had an Insulin reaction? _____ Date of last reaction: _____

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# Retina Consultants of Carolina, P.A. Medical History Questionnaire

## Social History

Do you: **Use Illegal Drugs** YES or NO **Live Alone** YES or NO
**Exercise** YES or NO **Drive** YES or NO

***Tobacco Use: (Check One)***
_____Current Every Day _____ Current Some Days _____ Never _____Former

***Alcohol Use (Check One)***

_____ Daily_____ Moderate_____ Rarely _____ Socially _____ Never

What is your current occupation?

_____

What is your highest level of education completed?

_____

Are you currently pregnant? Yes_____ No_____

## Family History

Any significant eye diseases which run in your family?

_____

_____

Any significant diseases which run in your family?

_____

_____

## Medication

Please list all medications including eye drops which you are currently taking or attach Medication list.

| Name of Drug | Dosage | Frequency | Reason for Use |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Allergies

Do you have any allergies to medications? No _____ Yes _____

**Medication** **Reaction**

1. _____
2. _____
3. _____

Do you have reaction problems with local or general anesthesia? No _____ Yes _____
Type of Reaction? _____
Any other allergic reactions: _____
Please Explain:

_____

Account #_____

# Retina Consultants of Carolina, P.A. Notice of Privacy Practices

## Patient Consent and Authorization

**Authorization to Release Information**

I authorize the release of medical information and the records concerning my treatment to Medicare, Medigap and/or other insurance companies and assign my claim for medical benefits to Retina Consultants to the extent permitted under applicable law or insurance agreements. I agree to allow Retina Consultants to request or release my information from or to other physicians or medical institutions as it deems necessary for my medical care and I further authorize the release of my medical records by such parties for such purpose. I agree to allow Retina Consultants to use my medical information and photography anonymously for the purpose of teaching or publication.

**Consent to/for Treatment**

I authorize the physician of Retina Consultants, their associates, technical assistants and other health care providers under their direction to provide diagnostic evaluations and treatment. I agree to papillary dilation for the purpose of examination and have been advised not to drive. I understand that no guarantee has or will be made to me regarding any my possible result or cure based on my examinations, and/or treatment.

**Demographic Information**

I authorize Retina Consultants of Carolina to use any of the demographic information I have provided. This may include home address, cell, home, work numbers, and social security number as needed for my complete treatment.

**Release of Health Information**

I authorize the person(s)/parties listed in the box below to receive all health information about appointments, treatment, payment information, and/or other information regarding my healthcare until I sign a new form voiding this form.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

**Notice of Privacy**

I have been given the opportunity to read in full the Privacy Notice provided by Retina Consultants of Carolina. I release Retina Consultants for all legal responsibility or liability that may arise from the above authorizations and agreements.

**Appointments**

Retina Consultants of Carolina strives to provide our patients with the best care possible, but are unable to render that care if appointments are missed or not scheduled according to your physicians' recommendation. Please be advised that failure to show for appointments or neglecting to schedule or reschedule an appointment can result in discharge from this practice.

_____ _____

**Signature of Patient or Legal Guardian** **Date**

Account #_____

# Retina Consultants of Carolina, P.A. Financial/Payment Policy

**Thank you for choosing our practice. We believe establishing a written financial policy is mutually beneficial for all parties. Please read this carefully and if you have any questions our staff will be happy to assist you.**

Payment is required at the time of service. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. This will be collected at every visit.

For all scheduled appointments, any balances must be paid prior to that days visit or your appointment may be rescheduled.

We participate with most insurance plans. It is your responsibility to understand your benefit plan, to know if we are a preferred provider, to know if a written referral or authorization is required to see our specialist, and that the referral is in our office at the time of your visit or be prepared *to reschedule, if needed.*

We will file your insurance as a courtesy to you, but you are responsible for all unpaid balances. Insurance claims have to be paid timely, therefore if the insurance balance is unpaid after 30 days you will be responsible and you can seek reimbursement directly from your insurance company.

## ***Please review the following guidelines effective July 11, 2014:***

- If we **are not** contracted with your insurance it will be necessary for you to pay in full for your visit at the time of service. We can provide information for you to file claim on your own.
- Self pay new patients are required to pay a $200 deposit at check in. This is JUST a deposit. The balance will be collected at check out. *A self pay discount may apply.*
- Self pay returning patients are required to pay a $100 deposit at check in. This is JUST a deposit. The balance will be collected at check out. *A self pay discount may apply.*
- Retina Consultants of Carolina offers three payment plans to assist our patients. *These will be discussed as necessary and are only for balances that meet requirements.*
- Bring a list of current medications to every visit.
- If you arrive more than **15** minutes late for your appointment, you may be asked to reschedule.
- We charge a **$20** fee, payable in advance, from the patient for any forms or detailed letters that are completed by our office. Please allow up to one week for this form to be completed.
- There will be a **$15** administrative fee for medical records requested for personal use, if more than one date of service is needed, then an additional .65 per page will be added.
- There will be a **$35** NSF fee for all returned checks. If not paid within 10 days check will be forwarded to the solicitor's office for collection.

We urge you to keep your account current. If your account becomes 90 days delinquent, your account will be referred to an outside collections agency for collections. At that point you cannot make an appointment at our office until paid in full. You will be responsible for your balance and the 30% collection fee which is added to your account.

If you need assistance or have questions about your insurance card or our policies, please contact our Billing Office at (864) 233-5722 or 800-530-0788 **PRIOR** to your appointment.

**I have read, understand and agree to Retina Consultants of Carolina's financial/payment policy. Failure to follow our policy may result in discharge from our practice. Retina Consultants will not deny emergency care.**

_____ _____

**Signature of Patient Name or Legal Guardian** **Date**