Please fill out completely

Legal Name

First: _____ Middle: _____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Email: _____

DOB: _____ Sex: _____ SS #: _____ Marital Status: M S W D

Ethnicity: Hispanic Non-Hispanic Unknown Race: Asian African American White American Indian Other

2nd Address: _____ Type: _____

City: _____ State: _____ Zip: _____

Insurance Information

Primary: _____ ID#: _____ Relation: Self Spouse Child Other

Subscriber Name: _____ DOB: _____ SS#: _____

Secondary: _____ ID#: _____ Relation: Self Spouse Child Other

Subscriber Name: _____ DOB: _____ SS#: _____

Tertiary: _____ ID#: _____ Relation: Self Spouse Child Other

Subscriber Name: _____ DOB: _____ SS#: _____

Physician Information

Referred by: _____ Phone # _____

Address: _____

Primary MD: _____ Phone # _____

Address: _____

Other MD: _____ Phone # _____

Address: _____

Emergency Contact

Name: _____ Relation: _____

Home #: _____ Cell #: _____ Work #: _____

Guarantor (MUST be filled out if patient is a minor!)

First: _____ Middle: _____ Last: _____

Address: _____ Relation: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

DOB: _____ Sex: _____ SS #: _____ Marital Status: M S W D

Ethnicity: Hispanic Non-Hispanic Unknown Race: Asian African American White American Indian Other

I authorize the physicians and staff of Retina Vitreous Associates of Florida to dilate, test and examine my eyes to the extent necessary to determine the underlying cause of my visual difficulties and to offer possible treatment options available to me.

PATIENT'S SIGNATURE:

Patient/Guardian Signature: _____ Date: _____

RETINA – VITREOUS ASSOCIATES OF FLORIDA

Diabetic Retinopathy • Macular Degeneration • Macular Hole Macular Pucker • Uveitis
Retinal Vascular Occlusion • Retinal Detachment • Pediatric Retina • Ocular Tumors

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Steven M. Cohen MD
Karina B. Findlay MD
David A. Eichenbaum MD
Alfred A White MD
Ashley M Crane MD
Priya S. Vakharia MD

DATE: _____

PATIENT'S NAME: _____ **DOB:** _____

GENERAL PATIENT / PHYSICIAN AGREEMENT

Please read the following paragraphs, initial below each paragraph that you have read, understand, and agree to the same.

CONFIDENTIALITY:

In an effort to provide the most efficient and effective healthcare, your treating physician will diagnose your illness according to your complaints, symptoms, test results, and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method, and/or any physician that can assist with the care of the patient, as long as confidentiality is kept at the physician level. I have read, understand, and agree with the above.

Patient/Guardian Initials: _____

FINANCIAL POLICY:

I authorize Retina Vitreous Associates of FL to bill my insurance company for services rendered. I realize that I will be responsible for co-payments and deductibles at the time of services. Any portion not covered by insurance will be billed to me. If I am uninsured, payment is expected at the time of service. Late charges of 2% will be assessed against the outstanding balance for any amount owed over 60 days. If it becomes necessary to collect any balance due through an attorney, then the patient (and/or spouse/guarantor) agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

I authorize Retina Vitreous Associates of FL to release medical information for insurance purposes. I authorize payment to be made directly to Retina Vitreous Associates of FL if an assignment is indicated by my insurance company. As a courtesy, Retina Vitreous Associates of FL will contact insurance companies for authorization for services required. Retina Vitreous Associates of FL is not responsible for lapses of insurance or for incorrect information.

I have read and understand the financial agreement above.

Patient/Guardian Initials: _____

FAILURE TO FOLLOW PHYSICIAN ORDERS:

"Physician Orders" are meant to improve and/or resolve the patient's medical condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician care and/or facility, thus releasing treating physician and/or facility from any injury or illness claim resulting from the patient's failure to follow orders. Not following orders given can included but is not limited to missing, postponing or refusal of additional tests to rule out, confirm or discover illness or failure to attend follow-up appointments. I have read, understand, and agree with the above.

Patient/Guardian Initials: _____

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FORM COMPLETION POLICY:

The ever increasing time and cost burden required to complete the multitude of forms being requested by our patients requires Retina Vitreous Associates of FL to implement the following charge policy for all forms.

- Completion of one (1) form page = $25
- Completion of two (2) or more form pages = $50 (maximum charge)

Forms that will be accessed a form completion fee include FMLA (Family & Medical Leave Act) forms, Disability forms, Back-To-Work forms, and miscellaneous forms.

When your forms are completed, Retina Vitreous Associates of FL will contact you to let you know that your forms are complete. Prior to the completed forms being distributed to patients, Retina Vitreous Associates of FL will collect the related fee via cash, money order, personal check, credit card, or debit card (MasterCard or Visa logo).

Patient/Guardian Initials: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

As provisioned by the Health Insurance Portability and Accountability Act of 1996 we must provide you with a detailed notice in writing of our privacy practices. By signing this notice you have acknowledged receipt of our Notice of Privacy Practices. (Dated April 14, 2003)

I have received a copy of Retina Vitreous Associates of FL's Notice of Privacy Practice.

Patient/Guardian Initials: _____

PATIENT'S SIGNATURE:

Patient/Guardian Signature: _____ Date: _____

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DATE: _____

PATIENT'S NAME: _____ **DOB:** _____

PHARMACY AND PRESCRIPTIONS

In order to better serve you, our patient's, we are utilizing an Electronic Prescription program to send your prescriptions directly to your pharmacy. In order to more efficiently process your prescriptions, please provide us with your primary pharmacy's information.

If you utilize a mail order pharmacy for long-term medications, please provide us with both your mail order pharmacy information and a local pharmacy you use as well. If your pharmacy participates, we will electronically send your prescription directly to them. If they do not participate, we will continue to call in your prescriptions for you.

Some medications can only be accepted by the pharmacy as a written prescription signed by your physician. If that is the case, we will still give you a signed prescription that you will need to take to your pharmacy.

PRIMARY PHARMACY

Pharmacy Name: _____

Address: _____

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

Phone #: (_____) _____ - _____ ☐ **Mail Order (3-month)** ☐ **Local Pharmacy** ☐ **Both**

SECONDARY PHARMACY

Pharmacy Name: _____

Address: _____

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

Phone #: (_____) _____ - _____ ☐ **Mail Order (3-month)** ☐ **Local Pharmacy** ☐ **Both**

NOTES

_____

_____

_____

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MEDICAL HISTORY

PATIENT'S NAME: _____ **DOB:** _____

Current vision problem: _____

Current eye medications: _____

VISION HISTORY:

Past eye problems & date of onset: _____

Past eye surgeries with dates: _____

PLEASE CIRCLE RT (RIGHT EYE) OR LT (LEFT EYE)

RT	LT	Lazy Eye since birth	RT	LT	Burning
RT	LT	Eye glasses @ child / adulthood	RT	LT	Feels like sand/lash in eye
		Date last updated: _____	RT	LT	Eye Discharge
RT	LT	Eye Injury: Type: _____	RT	LT	Tearing Eye
RT	LT	Blind Spot in vision	RT	LT	Eye Redness
RT	LT	Straight lines appear crooked/wavy	RT	LT	Eye Pain
RT	LT	Floating Spots/Cobwebs	RT	LT	Itchy
RT	LT	Loss of side vision	RT	LT	Matted eyes upon awakening
RT	LT	Droopy lid	RT	LT	Excessive light sensitivity
RT	LT	Glare or Halos	RT	LT	Bulging Forward of eyes
RT	LT	Foggy/Cloudy vision	RT	LT	Double vision
RT	LT	Blurring of vision:	RT	LT	Rapid flashing lights (Strobe)
		Circle one or both: Distance / Near	RT	LT	Yellow tinted vision

Do you take aspirin, Advil or other over the counter pain medicines? YES or NO

List: _____

Do you take dietary supplements or herbal supplements? YES or NO

List: _____

Current Medications / Dosages **Associated medical condition / # of years**

_____ for _____

_____ for _____

_____ for _____

_____ for _____

_____ for _____

TAMPA: 2705 W. St. Isabel St., Tampa, FL 33607, (813) 879-5795 / Fax (813) 877-4578
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MD: _____

REVIEW OF MEDICAL SYSTEMS - PATIENT:_____

(Circle) YES or NO if you have **current** problems – If Yes: √ Check any specific symptoms

Nose: Yes / No
___Loss of Smell
___Itching/allergies
___Sinus pain
___Nose bleeds

Ears: Yes / No
___Ringing
___Hearing loss
___Infection

Mouth: Yes / No
___Ulcers/sores
___Jaw cramping
___Chewing pain
___Painful to talk
___Tooth infection
___Hard to swallow

Cardio-vascular: Yes / No
___Chest pain at rest
___Chest pain on exertion
___Faintness
___Poor circulation
___Heartbeat skips
___Murmur
___High cholesterol
___Blood disorder
___Bleeding disorder
___Clotting problem

Respiratory: Yes / No
___Breath shortness
___Unable to breathe lying down
___Chest pressure
___Productive cough
___Bloody spit
___TB Exposure

Genitourinary: Yes / No
___Sores/ulcers
___Discharge
___Urination:
___Painful
___Difficult
___Increased
___Sexually transmitted disease:_____
___Kidney failure
___Kidney disease
___Premature birth of children
___Miscarriages

Musculoskeletal: Yes / No
___Neck stiffness/pain
___Lower back stiffness/pain
___Joint pain
___Joint swelling
___Osteoporosis
___Shoulder Ache
___Hip ache
___Arthritis:
Specify:_____
___Hand increase
___Head/hat size increase

Skin/hair/nails: Yes / No
___Skin rash
___Skin color change
___Hair increase
___Nail changes
___Skin ulcers
___Tender nodes

Neurological: Yes / No
___Numbness
___Weakness

Endocrine: Yes / No
___Palpitations
___Increased thirst
___Weight loss
___Loss of appetite
___Night sweats
___Chills
___Fatigue
___Fever

Lymphatic: Yes / No
___Tender nodes
___Swollen nodes

Psychiatric: Yes / No
___Difficult sleep
___Feel sad/blue
___Threatened
___Abused/hurt
___Alzheimer's

Allergic: Yes / No
___Itching
___Sneezing
___Watering eyes

Known allergies:
___Penicillin
___Codeine
___Sulfa drugs
___Iodine
___ Shell Fish
___ Other allergies
_____
_____
_____
_____

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Gastro-intestinal: Yes / No
___Diarrhea
___Abdominal pain
___Nausea /vomiting
___Fullness
___Mass
___Blood in stool
___Jaundice
___Liver problems
___Hepatitis

___Seizures
___Memory loss
___Unconsciousness
___Headaches
___Head Trauma
___Tender Scalp
___Claustrophobia

MD_____

Patient Name:_____

FAMILY HISTORY

	Age:	Living:	Medical problems or Cause of Death:
Mother:	_____	Y N	_____
Father:	_____	Y N	_____
Siblings	_____	Y N	_____
	_____	Y N	

_____

Please check the box for each condition that applies to your relative and indicate the relationship:
F: Father M: Mother S: Sister B: Brother GP: Grandparents C: Children O: Aunts/Uncles

Check:		Relative:	Check:		Relative:
_____	**Glaucoma:**	_____	_____	**Diabetes:**	_____
_____	**Macular Degeneration**	_____	_____	**Cancer:**	_____
_____	**Retinal detachment**	_____	_____	**Heart Disease**	_____
_____	**Retinitis Pigmentosa**	_____	_____	**Stroke**	_____
_____	**Blindness at birth**	_____			

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SOCIAL HISTORY

Please Circle the correct answer:

Do you drive? YES or NO

Do you drive at night? YES or NO

Do you have pets or animal exposure? YES or NO

If YES, what type of animals?_____

Do you use tobacco products? YES or NO

If YES, Type and frequency:_____

Call 1-800-QUITNOW for free help and information on stopping tobacco.

Do you drink alcohol beverages? YES or NO

If YES, how frequently? Drinks/day? _____

Do you use any recreational drugs? YES or NO

If YES, Type of drugs and frequency:_____

Do you eat undercooked meat or fish? YES or NO

MD:_____

Patient name:_____

OCCUPATIONAL HISTORY

Are you currently employed? YES or NO

Current Employer:

Name:_____

Address:_____

What is/was your occupation? _____

Do you feel safe at home? YES or NO

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Are you in a relationship in which you are being hurt or threatened emotionally or physically?
Call the Domestic Abuse Hotline 1-800-500-1119 for help.

Marital Status: M S W D

Do you have a Power of Attorney: N or Y: With Whom:_____

Can medical information be left with family members?: Y or N

I have completed this medical history to the best of my ability:

Signature:_____

Date:_____

MD:_____

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