REGISTRATION FORM

Welcome to Houston Retina Associates. We appreciate the opportunity of providing your eye care. Please complete the following information for our records. Thank You.

Today's date: _____/_____/_____

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home: ( )_____ Work: ( )_____

Mobile: ( )_____ Fax: ( )_____

Date of birth:_____ SS#: _____

Email Address: _____ Occupation: _____

Race: □ White □ Black / African American □ Asian / Pacific Islander □ Latino / Hispanic origin

□ American Indian / Alaskan Native □ Other: _____

Preferred language: _____

Marital status: Married / Single / Divorced / Separated / Widowed Spouse:_____

Referred by: _____ Phone:_____

Referring doctor's address:_____

Primary Medical Doctor Name: _____

Primary Medical Doctor Phone: _____

Medical Doctor Address:_____

Emergency Contact #1: _____ Phone:_____

Emergency Contact #2:_____ Phone:_____

Medical insurance (primary and secondary): _____

*** Policyholder name and date of birth: _____**

Policy No. _____ Group No. _____

*** Pharmacy Name:_____ Street: _____**

Phone: _____ City: _____

Patient History Questionnaire

Name: **Date:**

Please state reason for visit:

Previous eye conditions and surgeries: ____ None

List ALL Medical Conditions: ____ None

___ Diabetes _____ years	___ High Blood Pressure	___ Heart Disease	___ HIV / AIDS
___ Kidney Dialysis/Disease	___ Bleeding Disorder	___ Cancer	___ Thyroid Disease
___ Lung Disease	___ Vascular Disease	___ Stroke	___ High Cholesterol

List Other Medical Problems and Major Surgeries: ____ None

List ALL Current Medications (include non-prescription drugs): ____ No medications

Allergies and Drug Reactions: ____ No known drug allergies

Social History: Circle answer

Do you drink alcohol? No Yes (if yes, how often?) _____

Do you currently smoke, chew, or use cigars?
No Yes (if yes, how often?) _____

If you no longer smoke, when did you quit? _____

Do you abuse drugs? No Yes (if yes, explain) _____

Do you drive? No Yes

Do you live alone? No Yes

Do you reside in a skilled nursing facility / assisted living? No Yes

Have you ever had a blood transfusion? No Yes

Family History:

Any relative with:
___ Glaucoma? _____
___ Macular Degeneration? _____
___ Other?: _____

Patient History Questionnaire

Name:	Date:

Review of Systems:

If you are currently having any problems in the following areas, please circle and explain.

CONSTITUTIONAL: fever, weight loss, fatigue, trouble standing from chair □ **none**

SKIN: itching, rash, infection, ulcer, tumors (growths), other: □ **none**

LYMPHATIC: swelling or tenderness of lymph nodes, other: □ **none**

MUSCULOSKELETAL: muscle pain, cramps, joint pain, swelling, other: □ **none**

ENDOCRINE: confusion, fainting, nervousness, hot/cold intolerance, hair loss □ **none**

ALLERGY/IMMUNOLOGY: recurrent infections, hay fever, hives, food/drug allergy □ **none**

HEAD: headaches, dizziness, vertigo, other □ **none**

EARS: hearing loss, ringing, infections, other □ **none**
NOSE: bleeding, loss of smell, congestion, sinus problems, other
THROAT: dry mouth, loss of taste, difficulty swallowing, hoarseness, other

NECK: pain, swelling, stiffness, other: □ **none**

BREAST: tenderness, swelling, lumps, discharge, other: □ **none**

HEMATOLOGIC: fever/chills; bruise easily, prolonged bleeding, skin hemorrhages □ **none**

RESPIRATORY: wheezing, cough, difficulty breathing, asthma, other: □ **none**

CARDIOVASCULAR: (heart/ blood vessels): chest pain, swelling of extremities, shortness of breath, exercise intolerance, other □ **none**

GASTROINTESTINAL: (stomach/intestines): nausea, vomiting, constipation, diarrhea, pain/cramps, bleeding, other □ **none**

GENITOURINARY: (genitals/kidney/bladder): frequency, burning, pain or bleeding on urination, infections, incontinence, other □ **none**

NEUROLOGIC: weakness in arms or leg, numbness, or tingling, loss of consciousness, falls, difficulty walking, seizures, tremors, neuralgia, other □ **none**

PSYCHIATRIC: disorientation, mood swings, anxiety, depression, hallucinations □ **none**

This form completed by: Patient Family Staff

***Dilation of Eyes*: Due to the nature of your eye problem, it will be necessary to put drops in your eyes, which will dilate them. This means that the pupils will become and stay enlarged, letting in more light and cause blurring of vision particularly at near. A few patients have expressed concern regarding their ability to function after dilation. It has been our experience that the near vision is affected far more than the distance, and that most individuals are able to "get around", although some caution may be necessary in order to give the doctor full enlarged view of the back of the eye. This is vital part of the retinal examination.**

***Assignment of Benefits*: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me.**

***Patient Financial Responsibility*: I understand that I am financially responsible for charges not covered by this assignment, including any insurance deductible, copayment, or any charges which the insurance carrier declines to pay. Any quote given by Houston Retina Associates is an estimated amount. It is further agreed that any credit balance resulting from payment of insurance or other sources may be applied to any other accounts allowed to send physician by the insured or his/her family. Any overpayment that I make to Houston Retina Associates will be applied as a credit to my account. If I prefer a refund, I will need to contact the billing department for that request and to confirm my mailing address to issue the refund. I understand that if for any reason my insurance company does not pay my bill within 90 days, I will be responsible. Any returned checks will incur a $20 returned checks fee. In the event the account becomes delinquent and is turned over to a collection agency, I responsible for any collection, court or attorney fees. If I would like a copy of the billing policy of Houston Retina Associates, it is available to me upon request by contacting the billing department.**

***Release of information*: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s), to the patient, to a family member, or employer of the patient for all or part of the physician(s) charge, including but not limited to insurance companies, workers compensation carriers, welfare funds, or the patient's employer. The physician may also disclose at his discretion all or part of the patient record to other health-care professionals and in their staff for the purpose of coordinating the patient's medical care. This includes but is not limited to the patient's primary care physician and referring physician. The patient or responsible party may request and receive all or part of the patient's record at anytime.**

***Medicare and Medicaid patients certification-payment classification authorization to release information and payment request*: I certify that information given by any and applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorized any holder of medical or other information about me to the Social Security Administration or its intermediary carriers, any information needed for this or any related Medicare, Medicaid or other third party claim. I request that payment of authorized benefits be made on my behalf. I signed benefits payable for physician(s) services. I understand that I am responsible for my health insurance collectibles and co-insurance.**

_____ _____

DATE **SIGNATURE OF PATIENT OR RESPONSIBLE PARTY**

Acknowledgement of Review of
Notice of Privacy Practices

As the law requires, neither your physician nor any member of his staff are permitted to give or discuss any information, whether written or oral, regarding your condition or treatment to any third party (relative, friend, co-worker, employer, insurance company, etc.) without your express written authorization. However, a letter of consultation of your condition will be sent to the referring physician and your primary care doctor.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

Are there other family members or persons with whom you authorize us to discuss your medical information? □ Yes □ No If yes:

Name: _____

Phone: _____

Relationship: _____

Name: _____

Phone:_____

Relationship: _____