

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: _____
_____Mailing Address (If Different): _____

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

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

SSN: _____ Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed
(Your SSN is mandatory when scheduling anything at the hospital)

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: _____

Primary Insurance Information:

Name: _____ ID Number: _____

Policy Holder: _____ Policy Holder Date of Birth: _____

Address of Insurance Co: _____ Group Number: _____

Employer: _____**Secondary Insurance Information**

Name: _____ ID Number: _____

Policy Holder: _____ Policy Holder Date of Birth: _____

Address of Insurance Co: _____ Group Number: _____

Employer: _____

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: _____

Registered By: _____

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 _____

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: _____

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:

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

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: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

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