Retina & Vitreous Specialists

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Jasmine R. Elison, M.D. William F. Rachal, M.D.

PATIENT NAME: _____ ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: ( ) _____ AGE: _____ DATE OF BIRTH: ___/___/___

CELL PHONE #: ( ) _____ SOCIAL SECURITY #: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____ WORK PHONE #: _____

MARITAL STATUS: SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐

SPOUSE: _____ SPOUSE'S OCCUPATION: _____

EMPLOYER NAME AND ADDRESS: _____ PHONE: _____

IF PATIENT IS A MINOR, PARENTS' NAMES: _____

FATHER'S OR MOTHER'S EMPLOYER: _____ EMPLOYER'S PHONE: _____

NAME & PHONE OF PERSON (OTHER THAN SELF) THAT COULD BE REACHED WHEN APPOINTMENT CHANGE IS NECESSARY:

_____

REFERRING PHYSICIAN (OPHTHALMOLOGIST): _____

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____ PHONE: _____

WE WILL NEED TO COPY YOUR PICTURE IDENTIFICATION AS WELL AS YOUR INSURANCE CARDS. WE WILL BILL YOUR INSURANCE COMPANY FOR YOUR CHARGES TODAY. YOU ARE RESPONSIBLE FOR YOUR CO-PAYMENT.

INSURANCE: _____ ID #: _____

ADDRESS: _____ GROUP #: _____

SECOND INSURANCE: _____ ID #: _____

ADDRESS: _____ GROUP #: _____

I request that payment of authorized Medicare/Private Insurance benefits be made either to me or on my behalf to Dr. William Rachal for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature of Patient or Authorized Representative Date Signed

Patient_____ **Date**_____

Referring Doctor_____ 504-___-_____
Date of last exam_____
Primary Care Doctor_____ 504-___-_____
Date of last exam_____
Reason for today's exam_____

Previous eye surgeries_____
_____

Circle and Provide Information	**Right Eye**	**Left Eye**	**For How Long**
Do you have:			
Decreased vision			
Blurred vision			
Distortion			
Loss of vision			
Flashes			
Floaters			
Curtain or veil over vision			
Post op discomfort			
Red eye			
Tearing			
Foreign body sensation			
Discharge			
Pressure sensation			
Double vision			
No eye/vision complaints			

Social History
Do you drink alcohol? NO____ Social/Occasional_____ Daily_____
Do you smoke? NO___ Occasional___ ½ pack day___1 pack day___
1+pack day____

Occupation_____

Patient _____ **Date** _____

Drug allergies _____

Eye Medications	**When**	**Right Eye**	**Left Eye**

Blood Thinners (circle)

Coumadin Aspirin Plavix Arthritis Medications

Other Medications	**How Much**	**How Often**

Vitamins and Supplements

_____

_____

_____

Current Medical History

Diabetes x _____ Years/Months Last HA1C_____ Blood Sugar_____

Heart_____ High Blood Pressure_____ Stroke_____

Kidney_____ Cancer_____ Hepatitis_____

Glaucoma_____ Depression/Anxiety_____

List Surgeries _____

_____

_____

Patient_____ **Date**_____

Review of Systems (circle all that apply)

Cardiovascular: Chest pain Shortness of Breath Irregular Heartbeat None

Constitutional/General: Fever Weight loss or Gain Recent Illness Pregnant Muscle Weakness None

Endocrine: Excessive Thirst, Urination, Hair Loss Dry Skin Blood Sugar Control None

Gastrointestinal: Diarrhea Constipation Abdominal Pain Nausea Hepatitis Stomach Ulcer None

Kidney/Bladder: Dialysis Kidney Failure Painful or Frequent Urination Kidney Problems None

Blood/Lymph: Easy Bleeding or Bruising Lymphoma Leukemia HIV None

HENT: Hearing Loss Sore Throat Runny Nose Dry Mouth Ear Ache None

Skin/Integumentary: Rash Skin Cancer Severe Itching Loss of Hair None

Muscles/Bones/Joints: Joint Pain, Stiffness, Swelling Arthritis Back Pain Lupus Plaquenil Therapy None

Neurological: Headaches Weakness Fainting Tremor Stroke Seizure Numbness Tingling Loss of Memory None

Respiratory: Asthma Congestion Wheezing Cough Trouble Breathing Frequent Colds None

Family History (circle all that apply)

Macular Degeneration Glaucoma Cataracts Other Eye Problems

Diabetes Heart Disease High Blood Pressure Kidney Disease

Stroke Lupus Cancer None Unknown

Living Condition: (Circle) Alone With Others Nursing Home

ACKNOWLEDGEMENT OF NOTICEOF PRIVACY PRACTICES CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATONS

Name_____ Date of Birth_____

EMAIL Address_____

I understand that as part of my healthcare, **Dr Rachal and Dr Elison** originate and maintain health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

-A basis for planning my care and treatment.
-A means of communication among the many healthcare professionals who contribute to my care.
-A source of information for applying my diagnosis and surgical information to my bill.
-A means by which a third party payer can verify that services billed were actually provided.
-Tools for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare providers.

I understand that I have the right:

-To request restrictions on the use and disclosure of my protected health information.
-To receive confidential communications concerning my medical condition and treatment.
-To inspect and copy my protected health information.
-To amend or submit corrections to my protected health information.
-To receive an accounting of how and to whom my protected health information has been disclosed.
-To receive a printed copy of this notice.

RESTRICTIONS

We may contact you to confirm or reschedule an appointment. We may need to contact you concerning treatment or health related services.

ARE THERE ANY RESTRICTIONS ON WHO WE MAY CONTACT? (example: leave message with family member, discuss your condition or treatment plan with family member)

_____NO Restrictions

_____YES (if yes please specify who we should not contact)

_____

PLEASE ASK FRONT DESK IF YOU WOULD LIKE A COPY OF OUR PRIVACY NOTICE

SIGNATURE_____

Date _____ Witness Signature_____

September 2013

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Your eyes will be dilated each visit here.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare but is treatable with immediate medical attention.

I hereby authorize Dr. Rachal and /or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____

Patient (or person authorized to sign for patient) Date

_____ _____

Witness Date

6/3/08