Retina & Vitreous Specialists

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Jasmine R. Elison, M.D. retina2@bellsouth.net William F. Rachal, M.D.

PATIENT NAME: _____ ☐ MALE ☐ FEMALE

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

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

CELL PHONE #: ( ) _____

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 /WATERY EYE			
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____

Drug allergies_____

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

_____

_____

_____

_____

Name of Pharmacy_____**Telephone**_____
Pharmacy Address_____

Blood Thinners (circle)
Coumadin Aspirin Plavix Arthritis Medications

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

_____

_____

_____

_____

_____

_____

_____

_____

Vitamins and Supplements

_____

_____

Current Medical History
Diabetes Type 1 or Type 2 (circle one) x _____Years/ Months HA1C___
Blood Sugar_____ High Blood Pressure_____
Stroke_____ Kidney_____ Cancer_____ Hepatitis_____
Glaucoma_____ Depression/Anxiety_____ HEART DISEASE _____
HIGH CHOLESTEROL _____
List Surgeries_____

_____