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R. Gary Lane, MD
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Darrell E. Baskin, MD

9480 Huebner Rd, Suite 310
San Antonio, TX 78240
Phone (210) 615-1311
Fax (210) 615-6996
www.retinasanantonio.com

Retinal Consultants of San Antonio

Expert Care of the Retina, Macula and Vitreous

PATIENT REGISTRATION

Today's Date_____ **Referred by** _____

Patient Full Name _____

Home Address _____

City_____ State_____ Zip Code _____

Home Phone_____ Cell Phone _____

E-mail address _____ Date of Birth _____

Preferred Method of Contact: Home Phone / Cell Phone / Email

Social Security Number_____ Age _____ Gender: M / F

Marital Status: Single / Married / Divorced / Widowed

Language _____ Ethnicity _____

Employer/Parent's Employer_____ Occupation _____

Spouse name (Parent name if minor) _____

Spouse/Parent Phone _____

Emergency Contact (other than spouse) _____

Phone number (s) _____ Relationship _____

(Revision January of 2018)

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PATIENT REGISTRATION

Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name (if different from patient)		**Relationship to Patient**
Subscriber Social Security Number	**Subscriber Date of Birth**	**Subscriber Employer**

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name (if different from patient)		**Relationship to Patient**
Subscriber Social Security Number	**Subscriber Date of Birth**	**Subscriber Employer**

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Retinal Consultants of San Antonio to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

X_____ _____
Signature of Patient or Legal Representative **Date**

X_____ **X**_____
If Signed by Legal Representative, relationship to Patient **Signature of Witness**

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PATIENT MEDICAL HISTORY

Preferred Pharmacy _____ Phone _____

Street Address _____

City_____ State_____ Zip Code _____

SOCIAL HISTORY

When were you last hospitalized? _____

Living Status: Alone / Family / Caretaker / Nursing Home / Skilled Nursing Facility

Alcohol Status: None / Occasional / Socially / 1-2 Daily / 3+ Daily

Smoking Status: Never / Former / Current

Are you currently driving? Yes / No If applicable, are you pregnant? Yes / No

Have you fallen in the past 2 months? Yes / No

OCULAR HISTORY

Eye Disease(s): _____
_____

Past Eye Surgery(s): _____
_____

Current Eye Drop(s): _____
_____

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PATIENT MEDICAL HISTORY

MEDICAL HISTORY

Flu shot: Yes / No If yes, month / year received _____

Pneumonia Vaccine: Yes / No If yes, month / year received _____

Diabetic: Yes / No Insulin Dependent: Yes / No Year Diagnosed: _____

Last Blood Sugar #:_____ Date of Last Blood Sugar:_____

Last Hg A1C #: _____ Month of most recent HgA1C:_____

SYSTEMIC SURGICAL HISTORY

(Example: Tonsils removed, Hysterectomy, Colonoscopy)

_____

_____

_____

ALLERGIES

Any known drug allergies? Yes / No Are you allergic to Latex? Yes / No

DRUG ALLERGY HISTORY	REACTION
Example: Aspirin	*Hives & Nausea*

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PATIENT MEDICAL HISTORY

SYSTEMIC DIAGNOSIS HISTORY

[ ] Yes	[ ] No	AIDS/HIV	[ ] Yes	[ ] No	High Cholesterol
[ ] Yes	[ ] No	Seizures	[ ] Yes	[ ] No	Alzheimer's
[ ] Yes	[ ] No	Hypertension	[ ] Yes	[ ] No	Sjogren's
[ ] Yes	[ ] No	Arthritis	[ ] Yes	[ ] No	Kidney Disease
[ ] Yes	[ ] No	Sleep Apnea	[ ] Yes	[ ] No	Migraines
[ ] Yes	[ ] No	Stroke	[ ] Yes	[ ] No	Hepatitis A, B, or C
[ ] Yes	[ ] No	Osteoporosis	[ ] Yes	[ ] No	Thyroid Disease
[ ] Yes	[ ] No	Congestive Heart Failure			
[ ] Yes	[ ] No	Autoimmune Disease: _____			
[ ] Yes	[ ] No	Cancer: _____			
[ ] Yes	[ ] No	Other: _____			

PHYSICIAN INFORMATION:

Primary Care Physician _____ Phone # _____

Cardiologist _____ Phone # _____

Endocrinologist _____ Phone # _____

Rheumatologist _____ Phone # _____

Oncologist _____ Phone # _____

Neurologist _____ Phone # _____

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PATIENT MEDICAL HISTORY

MEDICATION

Did you bring a list of your medications today? Yes / No (**If NO, please list below**)

CURRENT MEDICATION	DOSAGE	SCHEDULE	ROUTE
Example: Lisinopril	*10mg*	*Once a Day*	*Oral, Injection, Spray, Puff*

FAMILY MEDICAL HISTORY	FATHER	MOTHER	SIBLING	CHILD
Example: Diabetes	✓		✓	
Macular Degeneration				
Retinal Detachment				
Glaucoma				
High Blood Pressure				
Diabetes				
Cancer				
Stroke				

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PATIENT MEDICAL HISTORY

REVIEW OF SYSTEMS	HOW ARE YOU FEELING TODAY?
Cardiology	[ ] Chest Pain [ ] Shortness of Breath
Constitutional	[ ] Fever [ ] Fatigue [ ] Weight Loss
Endocrine	[ ] Excessive Thirst [ ] Excessive Urination
Gastrointestinal	[ ] Abdominal Pain [ ] Nausea [ ] Diarrhea
Genitourinary	[ ] Blood in Urine [ ] Pain with Urination
Hematology	[ ] Easy burning [ ]Prolonged Bleeding
HENT	[ ] Hearing Loss [ ] Sore Throat [ ] Runny Nose
Integumentary	[ ] Rash [ ] New Mole
Musculoskeletal	[ ] Muscle Aches [ ] Joint Pain
Respiratory	[ ] Wheezing [ ] Coughing
Neurological	[ ] Headaches [ ] Dizziness [ ]Tremor [ ] Weakness

I authorize my physician and/or administrative and clinical staff Retinal Consultants of San Antonio to disclose general medical information and other protected health information to those situations described in the Notice of Privacy Practices.

X_____ _____
Signature of Patient or Legal Representative **Date**

X_____
If Signed by Legal Representative, relationship to Patient

X_____
Signature of Witness

(Revision January of 2018)