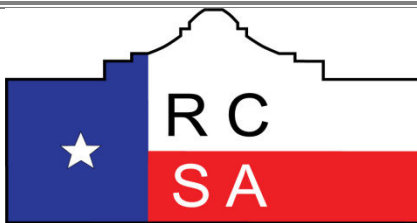


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## Retinal Consultants of San Antonio

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 \_\_\_\_\_

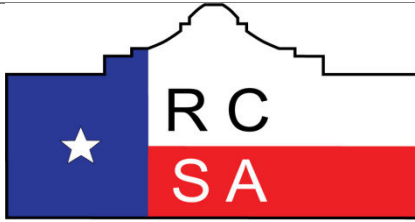
Spouse name (Parent name if minor) \_\_\_\_\_

Spouse/Parent Phone \_\_\_\_\_

Emergency Contact (other than spouse) \_\_\_\_\_

Phone number (s) \_\_\_\_\_ Relationship \_\_\_\_\_

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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.

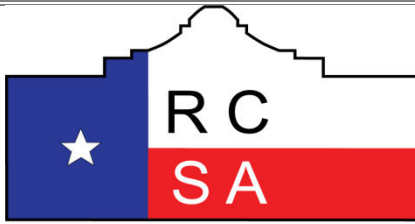
X \_\_\_\_\_  
 Signature of Patient or Legal Representative

\_\_\_\_\_  
 Date

X \_\_\_\_\_  
 If Signed by Legal Representative, relationship to Patient

X \_\_\_\_\_  
 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

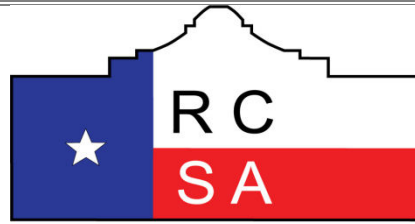
#### **OCULAR HISTORY**

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)*

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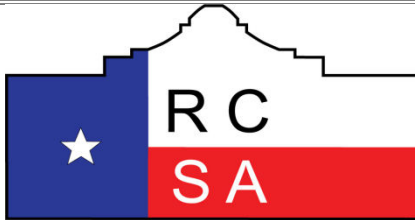
#### ALLERGIES

Any known drug allergies? Yes / No

Are you allergic to Latex? Yes / No

DRUG ALLERGY HISTORY	REACTION
<i>Example: Aspirin</i>	<i>Hives &amp; Nausea</i>

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### PATIENT MEDICAL HISTORY

#### SYSTEMIC DIAGNOSIS HISTORY

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

#### PHYSICIAN INFORMATION:

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Cardiologist \_\_\_\_\_ Phone # \_\_\_\_\_

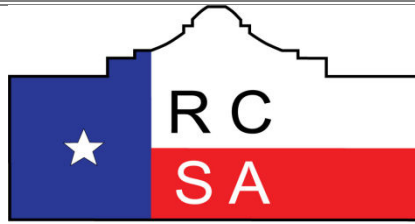
Endocrinologist \_\_\_\_\_ Phone # \_\_\_\_\_

Rheumatologist \_\_\_\_\_ Phone # \_\_\_\_\_

Oncologist \_\_\_\_\_ Phone # \_\_\_\_\_

Neurologist \_\_\_\_\_ Phone # \_\_\_\_\_

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### PATIENT MEDICAL HISTORY

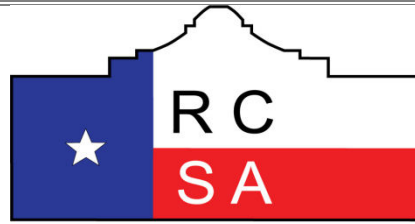
#### MEDICATION

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

CURRENT MEDICATION	DOSAGE	SCHEDULE	ROUTE
<i>Example: Lisinopril</i>	<i>10mg</i>	<i>Once a Day</i>	<i>Oral, Injection, Spray, Puff</i>

FAMILY MEDICAL HISTORY	FATHER	MOTHER	SIBLING	CHILD
<i>Example: Diabetes</i>	✓		✓	
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 <u>TODAY?</u>
Cardiology	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of Breath
Constitutional	<input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight Loss
Endocrine	<input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Excessive Urination
Gastrointestinal	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea
Genitourinary	<input type="checkbox"/> Blood in Urine <input type="checkbox"/> Pain with Urination
Hematology	<input type="checkbox"/> Easy burning <input type="checkbox"/> Prolonged Bleeding
HENT	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Sore Throat <input type="checkbox"/> Runny Nose
Integumentary	<input type="checkbox"/> Rash <input type="checkbox"/> New Mole
Musculoskeletal	<input type="checkbox"/> Muscle Aches <input type="checkbox"/> Joint Pain
Respiratory	<input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing
Neurological	<input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Tremor <input type="checkbox"/> 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**