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 #: (   ) ______________

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____

Occupation____________________________________

Patient ______________________________ **Date** ________________

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 ____

____

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 PROSTATE TROUBLE 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
ALZHEIMERS/ DEMENTIA 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

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

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