Retina & Vitreous Specialists

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Jasmine R. Elison, M.D. Mallika K. Doss, M.D. William F. Rachal, M.D.

Today's Date: ____/____/____ E-mail Address: _____

Last name: _____ First name: _____ MI: ____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: ____/____/____ Age: _____ ☐ Female ☐ Male

Primary Phone: _____ Secondary Phone: _____

If the patient is a minor, please check here ☐

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Referring Physician or Ophthalmologist (name and address):

_____

Primary Care Physician or Internist (name and address):

_____

We will need to make a copy of your picture identification and insurance card(s) when you arrive. We will bill your insurance company for your charges today. You will be responsible for your co-payment.

Primary Insurance: _____ Member ID: _____

Address: _____ Group Number: _____

Secondary Insurance: _____ Member ID: _____

Address: _____ Group Number: _____

I request that payment of authorized Medicare/Private Insurance benefits be made either to me or on my behalf to Dr.'s Rachal, Elison, and Doss 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: _____ Date: _____

Patient or Authorized Representative

Patient name: _____ Date: _____

Reason for today's visit: _____

Date of last eye examination: _____ Physician seen: _____

Please provide the following information:

Are you experiencing:	Yes	No	Right eye	Left eye	Duration of Problem
Decreased vision					
Blurred vision					
Distorted vision					
Loss of vision					
Flashes of light					
Floaters					
Curtain/veil over vision					
Post op discomfort					
Red eye(s)					
Tearing or watery eyes					
Foreign body sensation					
Discharge from eye(s)					
Pressure sensation					
Double vision					

☐ I do not have any vision complaints currently

Have you had cataract surgery? ☐ No ☐ Yes

If yes, please provide the following information: ☐ Right Eye ☐ Left Eye

Date of procedure(s): _____

Name of Doctor who performed the procedure(s): _____

Have you had laser treatment in one or both eyes? ☐ No ☐ Yes

If yes, please provide the following information: ☐ Right Eye ☐ Left Eye

Date of procedure(s): _____

Name of Doctor who performed the procedure(s): _____

Have you had any other eye surgeries? ☐ No ☐ Yes

If yes, please describe: _____ ☐ Right Eye ☐ Left Eye

Patient name: _____ Date: _____

Eye Medications: ☐ **I CURRENTLY DO NOT USE EYE DROPS**

Do you use:	Right Eye	Left Eye	Times used per day
Artificial Tears (Systane, refresh, etc.)			
Phenylephrine			
Tropicamide			
Atropine			
Cyclopentolate (Cyclogyl)			
Cyclomydril			
Dorzolamide-Timolol (Cosopt)			
Brimonidine-Timolol (Combigan)			
Brimonidine (Alphagan)			
Ketorolac			
Prolensa			
Diclofenac			
Latanoprost (Xalatan)			
Travoprost (Travatan)			
Bimatoprost (Lumigan)			
Timolol (Timoptic)			
Levobunolol (Betagan)			
Betaxolol (Betoptic)			
Dorzolomide (Trusopt)			
Brinzolamide (Azopt)			
Ofloxacin (Ocuflox)			
Ciprofloxacin (Ciloxan)			
Moxifloxacin (Vigamix, Moxeza)			
Gatifloxacin (Zymar, Zymaxid)			
Besifloxacin (Besivance)			
Prednisolone acetate (Pred Forte/ Pred Mild)			
Flurometholone (FML)			
Rimexolone (Vexol)			
Loteprednol (Lotemax)			
Difluprednate (Durezol)			

Patient name: _____ Date: _____

Medical History:

Name of preferred pharmacy: _____

Address: _____ Phone Number: _____

Drug allergies: _____ Food allergies: _____

Please check all that apply:	**Self**	**Mother**	**Father**	**Grand mother**	**Grand father**	**Brother**	**Sister**	**Children**	**Aunt**	**Uncle**
High Blood Pressure										
Stroke										
Kidney Disease										
Cancer										
Hepatitis										
Glaucoma										
Depression/Anxiety										
Heart Disease										
High Cholesterol										
Macular Degeneration										
Cataracts										
Lupus										
Retinal Detachment										
Diabetes										

ATTENTION: If you are diabetic, please provide the following information:

Type I ☐ Type II ☐

Date diagnosed: _____

Most recent blood sugar reading: _____ Most recent A1C: _____

Please list any medications that you are currently taking including vitamins and supplements (if you have a list, please provide us a copy):

_____

_____

_____

_____

_____

Are you taking any blood thinners (Aspirin, Eliquis, etc.) _____

Are you taking any eye vitamins (AREDS 2, Ocuvite, etc.) _____

Patient name: _____ Date: _____

Please list any previous surgeries:

_____

_____

_____

Vaccinations:

Flu: ☐ No ☐ Yes/ If yes, date received _____

Pneumonia: ☐ No ☐ Yes/ If yes, date received _____

Shingles: ☐ No ☐ Yes/ If yes, date received _____

Covid 19: ☐ No ☐ Yes/ If yes, date received _____

Do you drink alcohol? ☐ No ☐ Social/Occasional ☐ Daily

Do you smoke? ☐ No ☐ Occasional/Light Smoker ☐ 1 Pack daily ☐ 1+ pack daily

Review of Systems (Please check all that apply)

Cardiovascular	☑	**Endocrine**	☑	**Kidney/Bladder**	☑	**Neurological**	☑
Chest pain		Excessive thirst		Dialysis		Headaches	
Shortness of breath		Excessive urination		Kidney failure		Weakness	
Irregular Heartbeat		Hair loss		Frequent urination		Fainting	
Constitutional	☑	Dry skin		Painful urination		Tremor	
Fever		Control blood sugar		Kidney problems		Stroke	
Weight loss		**Gastrointestinal**	☑	Prostate trouble		Seizure	
Weight gain		Diarrhea		**Blood/Lymph**	☑	Numbness	
Recent illness		Constipation		Easy bleeding		Tingling	
Pregnant		Abdominal pain		Easy bruising		Alzheimer's	
Muscle weakness		Nausea		Lymphoma		Dementia	
HENT	☑	Hepatitis		Leukemia		**Respiratory**	☑
Hearing Loss		Stomach ulcer		HIV		Asthma	
Sore throat		**Skin/Integumentary**		**Muscles/bones**		Congestion	
Runny nose		Rash		Joint pain, stiffness		Wheezing	
Dry mouth		Skin cancer		Arthritis		Cough	
Earache		Severe itching		Back pain		Frequent Colds	
		Loss of hair		Lupus		Difficulty Breathing	
				Plaquenil therapy			

Attention: Please read and sign the following

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 temporarily 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 long your vision will be affected. Driving may be difficult after examination; therefore, it is best that you make arrangements for someone to drive you to and from your appointment.

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

I hereby authorize Dr.'s Rachal, Elison, and Doss and/or such assistants that may be designated by him/her to administer dilating eye drops that are necessary to diagnose my condition.

☐ I understand that my eyes will be dilated each visit unless stated otherwise by personnel.

Signature: _____ Date: _____

Patient or Authorized Representative

Witness: _____ Date: _____

Attention: Please read and sign the following

Acknowledgement of Notice of Privacy Practices Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

Patient name: _____ Date of Birth: _____

I understand that as a part of my healthcare treatment, Dr.'s Rachal, Elison, and Doss originate and maintain health records describing my health history, symptoms, examinations, test results, diagnoses, treatments 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 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 third party payer can verify that services billed were 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.

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

Restrictions: Are there any restrictions on whom we may contact?

(Example: leave message with a family member, discuss your condition or treatment plan with family member(s))

☐ No restrictions ☐ Yes/ If yes, please specify who we should not contact

_____

Please ask the front desk if you would like a copy of our privacy notice

Signature: _____ Date: _____
Patient or Authorized Representative

Witness: _____ Date: _____