RETINA NORTHWEST, P.C.

PATIENT REGISTRATION FORM

APPOINTMENT DATE

PATIENT INFORMATION:

Name _____ M / F
Last First M.I. Sex

Address _____
Street Address City State Zip

Phone #: Home (____) ____ - ____ Work (____) ____ Cell (____) ____ - ____
Area Code Area Code Area Code

Birthdate ____/____/____ Age ____ Social Security # _____

E-mail Address: _____

Would you like to enroll in our Patient Portal? ____ Yes ____ No ____ Already enrolled

Emergency Contact Name: _____ Phone number: _____

Race:
____ American Indian or Native American
____ Asian
____ Black or African American
____ Native Hawaiian or Pacific Islander
____ White
____ Declined to Answer / Not reported

Ethnicity:
____ Hispanic or Latino
____ Not Hispanic or Latino
____ Declined to Answer / Not reported

Preferred Language: _____

Marital Status (circle one): Single Married Widowed

Work Status:
_____ Working: ____ Full Time ____ Part Time
_____ Not Employed / Retired
_____ Student: ____ Full Time ____ Part Time

If working, please provide the following:
Occupation _____
Employer _____
Work Phone # (____) ____ - ____

PRIMARY INSURANCE INFORMATION:

Insurance Company Name _____

Subscriber Name _____ Policy/ID# _____

Subscriber's Date of Birth ____/____/____ Subscriber's Sex M / F

Relationship to Patient _____ Subscriber's Employer _____

SECONDARY INSURANCE INFORMATION:

Insurance Company Name _____

Subscriber Name _____ Policy/ID# _____

Subscriber's Date of Birth ____/____/____ Subscriber's Sex M / F

Relationship to Patient _____ Subscriber's Employer _____

Which Doctor Referred You to Retina Northwest? M.D. O.D. D.O.

First Name Last Name

Address City State Zip

Phone# (____) ____ - ____
Area Code

Who is Your Primary Care Physician? M.D. D.O.

First Name Last Name

Address City State Zip

Phone# (____) ____ - ____
Area Code

Retina Northwest, P.C.
www.retinanorthwest.com
RETINA & VITREOUS DISEASES
Physicians and Surgeons

Today's Date:_____

Please help us with your evaluation by providing detailed information. Thank You.

Your name:

Date of birth: Gender: ☐ Female ☐Male

Your family doctor (primary care provider): Date of last exam:

Your general eye doctor: Date of last exam:

Pharmacy name: Phone number:

Address: City: State:

Do you wear a vision correction? ☐ No ☐Glasses ☐Contact lenses
How many years have you worn: Glasses?_____ Contact lenses? _____
Type of glasses:_____ (Bifocal, reading, trifocal, single vision, progressive)
Type of contacts:_____(Soft, rigid gas permeable)

What changes in your vision led you to see an eye doctor recently?

What do you believe might be the problem?

Do you have any of these symptoms? ☐No (skip to next section)

Description	No	Right Eye	Left Eye	Notes: Severity? Duration?
No vision change				
Distortion (bent out of shape				
Blurring				
Dimness				
Blind spot or area				
Flashes or flickering				
Floaters				
Eyestrain				
Dry or burning eyes				
Severe light sensitivity				
Headache				

MRN number:

Please list any eye drops, medicines, and supplements that you take ***for your eyes:***					
Right Eye			Left eye		
Name	How often	For:	Name	How often	For:

Please list all other medicines and supplements, and the conditions for which you take them:					
Name	Dose	For:	Name	Dose	For:

Please list any allergic reactions you have to medications, food, etc.:	☐None
Name	Reaction

REVIEW OF SYSTEMS: Have you experienced any of these symptoms recently?	
Yes	Symptom
	FATIGUE
	FEVER
	NIGHT SWEATS
	HEARING LOSS
	COUGH
	WHEEZING
	CHEST PRESSURE OR DISCOMFORT
	IRREGULAR HEARTBEAT/PALPITATIONS
	CONSTIPATION
	DIARRHEA
	VOMITING
	DYSURIA (PAIN OR BURNING ON URINATION)
	HEMATURIA (BLOOD IN URINE)
	COLD INTOLERANCE
	HEAT INTOLERANCE
	POLYDIPSIA (INCREASED THIRST)
	POLYPHAGIA (INCREASED APPETTITE)
	POLYURIA (FREQUENT URINATION)
	DIZZINESS
	GAIT DISTURBANCE (TROUBLE WALKING)
	HEADACHE
	EMOTIONAL CHANGES
	RASH
	ARTHRALGIAS (PAINFUL JOINTS)
	JOINT SWELLING
	MUSCLE WEAKNESS
	BLEEDING
	BRUISING
	ENVIRONMENTAL ALLERGIES
	FOOD ALLERGIES

Have you had any of the following?		
Please check Yes or No and add details, such as duration and the name of any specialist treating you:		
Yes	Description	Notes
	Arthritis	
	Asthma	
	Blood Clots	
	Cancer (Please write type and management in notes section)	
	COPD	
	Diabetes	
	Heart Disease	
	Hepatitis/Liver Disease (Type:)	
	Hypertension	
	Renal Disease (Please write type and management in notes section)	
	Seizure Disorder	
	Stroke	
	Thyroid Disease	
	Sleep Apnea	
	Home Oxygen Therapy	
	Tuberculosis	
	Treatment to Thin Your Blood	
	Sexually Transmitted Disease	
	Stomach Ulcers/Colitis	
	Immune System Disorder	
	Anemia	
	Blood Transfusion	

Please list any major operations, hospitalizations, or injuries: ☐None (skip to next section)	
Date	Event

Please indicate if these illnesses occurred amongst your relatives: ☐ No information available							
Description	None	Father	Mother	Sister	Brother	Children	Grandparents
Retinal Detachment							
Retinal Disease							
Macular Degeneration							
Blindness							
Glaucoma							
Cataract							
Eye Tumor							
High Blood Pressure							
Heart Disease							
Diabetes							
Cancer							
Migraine							

Do you smoke tobacco? ☐Never
☐Quit How old were you when you quit? _____ How much in the past? _____
Type: ☐ Cigarettes ☐ Cigars ☐ Cigarillos ☐ Pipes
☐Yes How much currently? _____
Type: ☐ Cigarettes ☐ Cigars ☐ Cigarillos ☐ Pipes

Do you drink any alcohol? ☐None ☐Daily ☐Weekly ☐Monthly ☐Yearly
☐Occasionally ☐Rarely ☐Socially

Your occupation: _____ (☐ Retired)

Have you used any recreational drugs recently? ☐Never ☐No ☐Yes Type: _____

Do you have diabetes? ☐No ☐ Yes Year of onset: _____ ☐Type I ☐ Type II
Last Fasting Blood Sugar: _____(date) _____ (time)
Last HbA1c result: _____ Date of test: _____

Please list all previous surgery, laser, or drug treatment ***for your eyes:*** ☐None	
Date	Indicate which eye, the name of the surgeon, and the reason for the procedure:

I have answered these questions as completely as possible.

Signature: Date:

****

If you have completed this form on behalf of the patient, please print your name and relationship to the patient below.

Name: Relationship:

Retina Northwest Payment Policy

Thank you for choosing Retina Northwest for your medical care. We are committed to providing you with quality, personal health care and appreciate your commitment to adhere to our payment policy agreement.

Patients are expected to provide identification and a current insurance card(s) at time of service. We will bill your insurance when you provide us with current information. We bill insurance in accordance with all federal, state, and other contractual requirements in cases where we have an agreement or we are a participating provider. Please keep in mind that payment remains your responsibility. Even though you may have an insurance claim pending, you may receive a monthly statement for the outstanding balance of your account. Your insurance company will determine what amount, if any, you owe to Retina Northwest.

All accounts are due and payable within 30 days unless special arrangements are made with our Business Office.

For your convenience, we accept cash, money orders, checks, Visa, MasterCard, American Express, and Discover.

Attestation Statement:

I have read, understand, and agree to the above Retina Northwest Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copayments, coinsurance, and deductibles are my responsibility. I understand that delinquent accounts may be assigned to a collection service.

I authorize that my insurance benefits be paid directly to Retina Northwest.

I authorize Retina Northwest to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim in compliance with HIPAA regulations.

Signature _____ Date _____

Printed Name _____

RETINA NORTHWEST, PC

PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I understand that Retina Northwest (RNW) will use and disclose health information about me.

I have received a copy of RNW's Notice of Privacy Practices, effective September 23, 2013. This notice describes how RNW and its physicians, employees, staff and other office personnel may use and disclose health information about me. It explains my rights with respect to my health information and how I can exercise these rights.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon my request.

By signing below, I agree that I have reviewed and understood the information and that I have received a copy of the Notice of Privacy Practices.

Signature: _____ Date: _____ DOB: _____

Description of Patient Representative's Authority (if not signed by patient)_____

Release of Information Authorization

Many patients have a spouse, relative(s) and/or friend(s) who helps with and is involved in their medical care. In order for us to share information about your care with these people, we need a release from you. Please list below those people with whom we can discuss your medical care, including your appointments, medical conditions, recommended treatments, and account payment arrangements.

Name	Birthday	Relationship	Phone Number

_____ _____ _____

Patient Signature Date DOB