



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:	Ethnicity:
☐ American Indian or Native American	☐ Hispanic or Latino
☐ Asian	☐ Not Hispanic or Latino
☐ Black or African American	☐ Declined to Answer / Not reported
☐ Native Hawaiian or Pacific Islander	
☐ White	Preferred Language: _____
☐ Declined to Answer / Not reported	

Marital Status (circle one): Single Married Widowed
Work Status: If working, please provide the following:
☐ Working: ____ Full Time ____ Part Time Occupation _____
☐ Not Employed / Retired Employer _____
☐ Student: ____ Full Time ____ Part Time 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?	Who is Your Primary Care Physician?
First Name Last Name M.D. O.D. D.O.	First Name Last Name M.D. D.O.
Address City State Zip	Address City State Zip
Phone# () - Area Code	Phone# () - Area Code

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, 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 <u>for your eyes:</u>					
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	No	Description	Notes
		Arthritis	
		Asthma	
		Blood Clots	
		Cancer (Please write type and management in notes section)	
		COPD	
		Diabetes	
		Heart Disease	
		Hepatitis/Liver Disease (Type:)	
		High Blood Pressure (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)

[illegible]

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)
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Have you used any recreational drugs recently? ☐ Never ☐ No ☐ Yes Type: _____
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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 <u>for your eyes:</u> ☐ 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: _____