# TAYLOR RETINA CENTER

**Patient Legal Name**_____

**Date of Birth**_____ **Sex**_____ **SSN**_____

**Race** WHITE / BLACK / NATIVE AMERICAN / ASIAN / OTHER **Primary Language**_____

**Marital Status** SINGLE / MARRIED / DIVORCED / WIDOWED

**Home Address**_____ **State**____ **City**_____ **Zip**_____

**Home Phone**_____ **Cell Phone**_____

**Email Address**_____

**Employer**_____ **Occupation**_____

**Emergency Contact**_____ **Relationship to Patient**_____

**Phone Number**_____

**Insurance Coverage Information:**

**Policy Holders name**_____ **Date of Birth**_____

**Relationship to Patient**_____

**Primary Care Physician (PCP) Information:**

**Name**_____ **Office**_____ **City**_____

**Referring Physician Information:**

**Name**_____ **Office**_____ **City**_____

**Other Physicians to Whom Patient Wants Communication Sent:**

**Name**_____ **Office**_____ **City**_____

**Authorization: I authorize Taylor Retina Center to furnish information to my insurance carrier(s) concerning this service. I irrevocably assign to the Taylor Retina Center all payments for medical service rendered. I understand that I am financially responsible for all charges regardless of whether they are covered by my insurance carrier(s). I will pay for office visit charges at the time of service. Section 1862 (A)(1) of the Medicare law limits payment of benefits in only those services that are "reasonable and necessary." If Medicare finds that any particular service is not reasonable and necessary, even though it would otherwise be covered, it will deny payment for that service.**

**Signature of Responsible Party** _____ **Date:** _____

# TAYLOR RETINA CENTER

## RELEASE OF MEDICAL INFORMATION

**Patient Legal Name_____ Date of Birth_____**

**By signing below, I authorize Taylor Retina Center to release my Medical and Billing information to:**

**Name of Designated Person #1:**

**Name_____ Relationship_____**

**Name of Designated Person #2:**

**Name_____ Relationship_____**

**Name of Designated Person #3:**

**Name_____ Relationship_____**

**If I change my mind about the people or the contact information I have listed in this form, I will complete a new form with such changes. I understand that the Taylor Retina Center will ask for identification of the person picking up any medical records.**

**Patient Signature_____ Date_____**

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

**I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA") I have certain rights to privacy regarding my protected health information (PHI).**

**I received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.***

**Patient Name or Legal Guardian Printed_____**

**Signature_____Date_____**

# TAYLOR RETINA CENTER

## MEDICAL HISTORY

| Circle any and all conditions that apply to <u>you</u> or circle none--------→ NONE | |
|---|---|
| **EYES** | Blindness / Cataracts / Glaucoma / Amblyopia / Eye trauma<br>Retinal detachment / Diabetic retinopathy / Lazy Eye<br>Macular degeneration |
| **EAR, NOSE, THROAT** | Allergic rhinitis / Vertigo / Seasonal allergies |
| **GASTROINTESTINAL** | Hernia / Peptic ulcer disease / Crohn's / reflux (GERD)<br>ulcerative colitis |
| **RESPIRATORY** | Asthma / COPD / emphysema / chronic bronchitis |
| **GENITOURINARY** | Kidney stones / kidney failure |
| **DERMATOLOGIC** | Psoriasis / Rosacea / Cancer: (**specify type**)_____ |
| **ENDOCRINE** | Grave's disease / thyroid disease /<br>Diabetes (**specify type)** Type I / Type II<br>Insulin dependent? ____ Uncontrolled / Controlled |
| **ALLERGIC IMMUNOLOGIC** | HIV+ / lupus / Sjogren's syndrome / rheumatoid arthritis /<br>herpes simplex virus / hepatitis A/B<br>Shingles / Reiter's syndrome / ankylosing syndrome |
| **CARDIOVASCULAR** | A-Fib / congestive heart failure / heart attack / heart<br>arrhythmia / high blood pressure / high cholesterol<br>**Pacemaker or defibrillator _____**<br>**cardiac stents? YES or NO** |
| **HEMATOLOGY** | Anemia / blood clots in lungs / blood clot in legs |
| **MUSCULOSKELETAL** | Fibromyalgia / multiple sclerosis / arthritis osteoporosis |
| **PSYCHIATRIC** | Anxiety / Depression / Bipolar disorder / Insomnia |
| **NEUROLOGICAL** | Alzheimer's / dementia / Parkinson's / stroke / autism<br>bell's palsy / epilepsy / schizophrenia / migraines |

**Please list any other diagnosis if not listed above:**

_____

_____

| **FEMALES** | Are you pregnant? **YES NO /** Are you nursing? **YES NO** |
|---|---|

## FAMILY HISTORY (Living or Deceased)…if yes please list who

**Macular Degeneration**_____ **Glaucoma** _____
**Diabetes** _____ **Retinal Detachment** _____
**Cancer** _____ **Stroke** _____
**Heart Disease** _____ OTHER: _____

**DO YOU USE TOBACCO?** Never / Current Everyday / Current Someday / Former

**DO YOU CONSUME ALCOHOL?** Never / Occasionally / 1-2 drinks a day / 3-4 drinks a day

## *PHARMACY INFORMATION*

NAME_____ PHONE NUMBER (____) _____
ADDRESS _____ CITY_____ STATE_____

## Please list ALL prescription medications:

_____ _____
_____ _____
_____ _____
_____ _____

**Please list all drug ALLERGIES (please include reactions to allergy)** → NKDA

_____ _____
_____ _____
_____ _____

## Please list any General surgeries or Eye surgeries / Procedures

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Taylor Retina Center staff of any changes in my medical status.
**Patient signature** _____ **Date** _____