University Retina and Macula Associates PC

Confidential Patient Registration Form

Appointment Date: _____ Today's Date: _____

Primary Information

Last Name: _____
First Name: _____MI:_____
Date of Birth: Month _____Day _____Year _____
SSN:_____

Gender: ◯ **M** ◯ **F** ◯ **_____**

Marital Status: **Married** **Single** **Divorced** **Widowed** **Separated**

Contact Information

Home Phone: _____ Ok to leave message **YES NO**
Mobile Phone: _____ Ok to leave message **YES NO**
Work Phone: _____ Ok to leave message **YES NO**
Email:_____

Preferred Language: **English Spanish Polish Other_____**

Address Information:

Street Address:_____Apt/Unit#:_____
City:_____State:_____Zip Code:_____

Type of Residence: **House/Apt** **Assisted Living Facility** **Skilled Nursing Facility**

Employer: _____
Occupation: _____
Work Phone: _____

Address: _____
◯ **Full Time** ◯ **Part Time** ◯ **Unemployed** ◯ **Disabled**
◯ **Retired** ◯ **FT Student** ◯ **PT Student**

Race:

◯ **American Indian or Alaskan Native**
◯ **Asian**
◯ **Black or African American**
◯ **Native Hawaiian or Pacific Islander**
◯ **White**
◯ **Other Race**
◯ **Declined**

Ethnicity:

◯ **Hispanic or Latino**
◯ **Not Hispanic or Latino**
◯ **Declined to Specify**

How did you hear about us?

◯ **Friend/Relative** ◯ **Internet** ◯ **Other_____**
Referring Doctor: _____
Reason: _____

EMERGENCY CONTACT INFORMATION

Spouse / Significant Other

Last Name: _____
First Name: _____
Home Phone: _____
Mobile Phone: _____
Work Phone: _____
Relation to Patient: _____

May University Retina discuss detailed information regarding diagnoses and treatment with this person? YES NO

Friend or Relative Not Living with You

Last Name: _____
First Name: _____
Home Phone:_____
Mobile Phone: _____
Work Phone: _____
Relation to Patient:_____

May University Retina discuss detailed information regarding diagnoses and treatment with this person? YES NO

INSURANCE INFORMATION

The receptionist will need to obtain a copy of your insurance card

Primary Insurance Information

Insurance Name: _____

ID:_____ Group:_____

Subscriber Name: _____

DOB: _____ Relation to Patient: _____

Employer Name: _____

Employer Address: _____

Secondary Insurance Information

Insurance Name: _____

ID:_____ Group:_____

Subscriber Name: _____

DOB: _____ Relation to Patient: _____

Employer Name: _____

Employer Address: _____

The information provided by me to University Retina and Macula Associates, P.C. is true to the best of my knowledge.

University Retina and Macula Associates, P.C. will file insurance claims for all reimbursable services to your insurance carrier. I authorize the release of medical information to my insurance company necessary to process my claims.

I authorize University Retina and Macula Associates, P.C. to collect payment from my insurance carrier(s)for any medical or surgical benefits received.

I understand that I am responsible for all deductibles, co-payments, coinsurance and non-covered services amounts for the services rendered.

_____ _____

Signature of Patient or Responsible Party **Printed Name**

MEDICAL PROVIDER INFORMATION

Primary Medical Doctor

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____

Referring Doctor

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____

Optometrist

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____

Cardiologist

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____

Other physician(s) involved in your care

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____

Patient Name: _____ **Appointment Date:** _____

Pharmacy Information

Name: _____

Address: _____

City: _____State: _____Zip: _____

Phone Number: _____

Allergies

No Known Drug Allergies (NKDA) ◯

Substance(s)	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Ocular & Systemic Medication(s) Information **No Ocular Meds** ◯ **No Systemic Meds** ◯

Please List all EYE drops, EYE Medications, and SYSTEMIC medications (including Herbal and Dietary Supplements)
Prescribed by your eye doctor and/or primary care physician

Medications	Strength	How many/How much	How often

Surgical History **No Prior Surgical History** ◯

Please list all prior EYE surgeries, EYE procedures, and SYSTEMIC surgeries/procedures

Surgery/Procedure	Date	Performing Physician

Patient Name: _____ **Appointment Date:** _____

Medical History

When were you last examined by an ophthalmologist or optometrist?

Date: _____ **Doctor Name:** _____

OCULAR No Past Ocular History ◯ **SYSTEMIC** No Past Medical History ◯

Have you ever had?	Y	N	Date of Onset		Have you ever had?	Y	N	Date of Onset
Retinal Detachment					**Diabetes**			
Flashes					Type I or Type II			
Floaters								
Loss of Vision					High Blood Pressure			
Diabetic Retinopathy					Asthma/Emphysema/TB/ COPD			
Macular Degeneration								
Hereditary Eye Disease					**Kidney Problems**			
Glaucoma					Dialysis			
Retinal Vein Occlusion								
Ocular Migraines					Cancer			
Blurred Vision					Migraines			
Cataract					Weakened Immune System			
Extreme Dry Eyes					High Cholesterol			
Eye Pain or Soreness					Other Illnesses			
Other								

Family History No Known Past Family History ◯

Please answer the following question to the best of your knowledge

Do any blood relatives, LIVING or DECEASED, Have any of the following conditions?

Condition	Relation / Status	Condition	Relation / Status
Diabetes		Cancer	
High Blood Pressure		Hereditary Eye Disease	
Heart Disease		Diabetic Retinopathy	
Tuberculosis		Glaucoma	
Kidney Disease		Macular Degeneration	
Migraine Headaches		Retinal Detachment	
Stroke		Other	

Social History

SMOKING / TABACCO USE	ALCOHOL CONSUMPTION	SUBSTANCE ABUSE
◯ Never Smoker	◯ None	◯ NONE
◯ Former Smoker	◯ Occasional/Social	◯ Inhaled / Smoked Substance
Year Quit:	◯ Current Consumption	◯ Orally Ingested Substance
◯ Current Every day Smoker	How Much?	◯ Other
How Much?	◯ Year Quit, if Applicable	
◯ Current Some day Smoker		
How Often?		

Patient Name: _____ **Appointment Date:** _____

Do you drive? ◯ YES ◯ NO If YES, do you have visual difficulty when driving? ◯YES ◯NO If YES, describe:

Are you currently pregnant or nursing? ◯ YES ◯ NO

Do you wear glasses? ◯ YES ◯ NO if YES, how old is your present pair of lenses? _____

Do you wear contact lenses? ◯ YES ◯ NO if YES, how old is your present pair of lenses? _____

Type of contact lenses ◯ Rigid ◯ Soft ◯Extended wear ◯ Other_____

Have you ever been exposed to or infected with: ◯ Gonorrhea ◯ Hepatitis ◯ HIV/AIDS ◯ Syphilis

Review of Systems

A review of systems is required when you have a medical eye exam. This information is needed as many systemic diseases and medical problems may affect your vision and eye health.

ALLERGY/IMMUNOLOGY
- ◯ Autoimmune disease
- ◯ Eczema
- ◯ Eggs
- ◯ Seasonal allergies
- ◯ Shrimp
- ◯ Susceptible to infections
- ◯ Other: _____

CARDIOVASCULAR
- ◯ Chest pain/pressure
- ◯ Shortness of breath when lying flat
- ◯ Swelling of feet/ankles

CONSTITUTIONAL
- ◯ Difficulty sleeping
- ◯ Feeling of weakness
- ◯ Fever
- ◯ Hot flashes
- ◯ Loss of appetite
- ◯ Unexplained weight loss

HEAD/EARS/NOSE/THROAT
- ◯ Difficulty swallowing
- ◯ Frequent headaches
- ◯ Hearing loss
- ◯ Ringing in ears

ENDOCRINE
- ◯ Excessive hunger
- ◯ Excessive thirst
- ◯ Fatigue
- ◯ Thyroid/other glands

GASTROINTESTINAL
- ◯ Blood in stool
- ◯ Constipation
- ◯ Diarrhea
- ◯ Heartburn or indigestion
- ◯ Vomiting
- ◯ Reflux

GENITOURINARY
- ◯ Blood in urine
- ◯ Difficulty urinating
- ◯ Kidney failure
- ◯ Painful urination

HEMATOLOGY/ONCOLOGY
- ◯ Bleeds easily
- ◯ Easy bruising
- ◯ Prolonged bleeding
- ◯ Swollen lymph nodes
- ◯ Anemia

INTEGUMENTARY
- ◯ Recent hair loss
- ◯ Skin cancer
- ◯ Skin rashes
- ◯ Skin sores

MUSCULOSKELETAL
- ◯ Arthritis
- ◯ Joint pain
- ◯ Muscle aches

NEUROLOGICAL
- ◯ Confusion
- ◯ Dementia
- ◯ Frequent headaches
- ◯ Numbness
- ◯ Poor balance

PSYCHIATIC
- ◯ ADD / ADHD
- ◯ Anxiety
- ◯ Depression

RESPIRATORY
- ◯ Coughing
- ◯ Shortness of breath
- ◯ Sleep apnea
- ◯ Wheezing

◯ All of the above systems were reviewed with **NEGATIVE RESPONSES**

POSITIVE RESPONSES: Are you currently under the care of physician for any of the above conditions? ◯ **YES** ◯ **NO**

UNIVERSITY RETINA

NOTICE OF PRIVACY PRACTICES
SHORT FORM SUMMARY

This Notice is Effective as of: January 1, 2022

This is only a summary of our Notice of Privacy Practices. Please review the full Notice following this summary to learn how we use and disclose medical information about you and your rights concerning these uses and disclosures.

How We Use and Disclose Your Information

We will obtain your written authorization for any uses and disclosures of protected health information "PHI" not described in the Notice of Privacy Practices.

Treatment, Payment, and Health Care Operations. We may use your PHI in order to provide your medical care; to bill for our services and to collect payment from you or your insurance company; and for the general operation of our business.

Marketing, Fundraising, and Sale of PHI. We will obtain your prior written authorization before sending you certain marketing communications. We may use or disclose your demographic information in order to contact you for our fundraising activities, but you have the right to opt out of such communications. We will not sell your health information without your prior written authorization.

We may use your PHI as otherwise authorized or required by law for such purposes as:

- public health reporting and oversight activities
- judicial, administrative, or law enforcement proceedings
- complying with workers' compensation laws
- communicating with your family or caregivers
- sending appointment reminders

You Have the Right to:

- Request certain restrictions on our use and disclosure of your PHI.
- Request communications from us by specific means or locations.
- Inspect and copy your medical record.
- Ask us to correct the information in your medical record.
- Receive an accounting of disclosures of your PHI by our practice.
- Be notified in the case of a breach of unsecured PHI.

CONTACT US

Contact our Privacy Officer with any questions, comments, or complaints or to exercise any of your rights at Questions@uretina.com or by phone at 708-687-2222

UNIVERSITY RETINA

REQUEST FOR CONFIDENTAL COMMUNICATION

I, _____(print name), hereby request University Retina & Macula Associates, P.C. to keep communications regarding my protected health information confidential. To accomplish this, please adhere to the following requests.

Phone:

You may contact me by phone at: (_____) _____ - _____Home and/or
(_____) _____ - _____Cell

Send text messages to the cell number Yes ☐ No ☐

Leave messages on answering machine Yes ☐ No ☐

Leave messages with any other person Yes ☐ No ☐

Discuss detailed information regarding my diagnoses and treatment with the following person(s):

Name: _____Phone #:(_____)_____-_____ Relationship: _____

Name: _____Phone #:(_____)_____-_____ Relationship: _____

Name: _____Phone #:(_____)_____-_____ Relationship: _____

Mail:

Contact me at the following address:

_____
Street

_____
City *State* *Zip*

We can send your statement via mail or send e-statements via patient portal or text

☐ I would like to opt out of paper statements and receive only e-statements via patient portal

☐ I would like to receive mailed paper statements

This request may be changed or revoked by filing a new request or revoking this one in writing.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____

Patient Name: _____ **Appointment Date: _____**

2022 Financial Policy Acknowledgment

I,_____ (patient), acknowledge that I have received University Retina's Financial Policy for the year 2022 and I agree to the terms stated.

_____ _____

Signature of Patient or Responsible Party Date

_____

Printed Name

Notice of Privacy Practices

I,_____(patient), acknowledge that I have received a copy of the University Retina's Notice of Privacy Practices regarding privacy of personal health information.

_____ _____

Signature of Patient or Responsible Party Date

_____

Printed Name
