

PLEASE COMPLETE ALL THE ENCLOSED INFORMATION BEFORE ARRIVING FOR YOUR APPOINTMENT. YOU WILL BE DILATED AT EVERY VISIT THEREFORE IT IS ALWAYS RECOMMENDED THAT YOU BRING A DRIVER.

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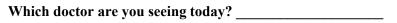
We would like to welcome you to Southeastern Retina Associates. Please visit our website www.southeasternretina.com for more information about our practice, physicians, and various locations in Tennessee, and the surrounding states.

Thorough retinal evaluation requires that you spend more time in our office than would be necessary for a general eye examination. During the initial visit, we will ask you questions about your eyes, your general health, and any medications that you take. Collection of medical information and a variety of tests must be performed both before and after dilation of the pupils. Please bring a companion to drive you home after the dilated eye exam.

Please remember that traffic and parking can add to delays at some of the different locations and to allow for additional travel time. If you discover that you are going to be late please call us as soon as possible. We do understand unforeseeable delays may occur. We will try to accommodate the occasional patient who is late, but this may not always be possible without compromising the quality of your care and depriving other patients of their own scheduled appointment times.

Thank you,	
Southeastern Retina Associates	
Appointment Date:	
A	
Appointment Time:	
Appointment Location:	
Appointment Location.	

Patient Demographics



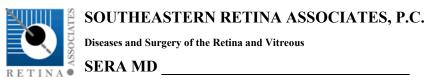
Signature:



Patient's Name:				Res	sponsible Pa	rty:
Address:		Zip: _		City:		State:
Sex: □ Male □ Female	Title	□ Mr.	□ Mrs.	□ Miss	□ Other	
Phone:	_ □ Work				□ Cell	
Please check the box for the phone number	er above that	t you w	ould lik	e us to u	ise as your p	rimary contact.
E-mail:	M	arital S	Status:	□ Single	□ Married □	Divorced Widow Unknown
Date Of Birth:/ Soc	ial Security a	#		-	Em	ployer:
Emergency Contact:						
Patient's Employer:		Primar	y Insura	nce Nam	ne:	
If you have insurance through through someon	ie else:					
Subscriber Name:		Subscr	iber Dat	e of Birt	h//_	
Subscriber's Employer:						
What Physician referred you to us? NAME of	& ADDRESS:					
Primary Care Physician? NAME & ADDRE						
Trimary Care I hysician. Triming & Hobbit						
Responsible Party if patient is a Minor:						
Name:	Address:					Phone:
Relationship: Date of Birth: _	//		SSN:		<u>-</u>	
Employer:	Work	Phone: _			Cell:	
Spouse's Name:				Spouse	's SSN#:	
Spouse's Employer:						
Spouse's Date of Birth://						
Is your visit related to an accident? Yes	⊐ No	Will this	s be cove	red under	· Worker's Coi	npensation? Yes No
I authorize the disclosure of my personal health information to my transmittal, to carry out treatment, payment, or health care opera agree to pay all reasonable collection costs and attorney fees in the rectly to Southeastern Retina Associates, PC should they elect to rethorization. Signature:	ntions (TPO). I accepte event of default creceive such paymen	pt full finan of payment nt. My sigr	cial respons on my char nature below	sibility for se	rvices rendered by ser authorize and requal have read and	Southeastern Retina Associates, PC., and uest insurance payments be made di-
MEDIGAP (SIGNATURE ON FILE STATEMENT FOR MEDICARE TO	CROSSOVER TO 2N	D INSURAN	ICE)			
Name of Beneficiary	HIC	N			Medigap	Policy Number
I request that the payment of authorized Medigap benefits be may vider. I authorize any holder of medical information about me to benefits payable for related services. Beneficiary Signature	release to	· 		any	information neede	
My signature below indicates that a copy of The Pri	ivacy Policy for	Southea	stern Reti	ina Associ	ates, PC has be	en made available to me.

MEDICAL AND OCULAR

Account # _____



Patient Name:				Sex:	Age:	Date:
Eye Doctor (Not Retina)):			City or Add	dress:	
Medical Doctor:				City or Ad	ldress:	
		Please an	swer the following qu	estions to the bes	t of your	ability.
	G		ef description, and whi		•	•
		,	1 /	J	•	
Present Illness Please	describe :	your current ey	e problem:			
Ocular History Have y	vou ever	had any of the	following:			
		· ·		Right □ Left	Surgeon a	nd Date:
Macular Degeneration				_	_	
9						
						Problems:
yyyyyy	e	,,	- g ,		J -	
Medical History			ve you ever had			
Seasonal Allergies	□ Yes		Food Allergies			se List:
High Blood Pressure	□ Yes		Controlled with n			
Heart Problems	□ Yes	□ No	□ Heart Attack	□ Angina □	Rhythm	Problems □ Congestive Failur
			□ Other			
Neurology	□ Yes	□ No	□ Stroke	□ Seizures □	Migraine	□ Tremors
			□ Parkinson's	□ Neuropathy □	Bells Pal	sy
Endocrine	□ Yes	□ No	□ Diabetes	How I	Long?	Last Blood Sugar
			□ Type 1	□ Type 2		
			□ Thyroid	□ Sarcoidosis		Last A1C Hemoglobin
Pulmonary	\square Yes	□ No	□ Asthma	□ Emphysema	\Box Lung	Disease □ COPD □ Phlebitis
			□ Tuberculosis	□ Shortness of E	Breath	□ Pneumonia □ Bronchitis
Genitourinary	□ Yes	□ No	□ Prostate	□ Kidney Diseas	se	□ Kidney Stones □ UTI
Gastroenterology	\square Yes	□ No	□ GERD –reflux	$ \Box \ IBS$	□ Ulcer	s □ Hiatal Hernia
			□ Acid Reflux	□ Diverticulitis	□ Crohr	's Disease
Hematology	□ Yes	□ No	□ Anemia	□ Lupus	□ Hepat	itis High Cholesterol
			\Box HIV	□ Sickle Cell Di	sease	□ Lyme Disease
			□ Cancer	□ Skin □ Breas	t 🗆 Prosta	ate Lung Other
Rheumatology	□ Yes	□ No	□ Arthritis	□ Sjogren's Syn	drome	□ Rheumatoid Arthritis
Psychiatry	□ Yes	□ No	□ Depression	□ Anxiety □ D	ementia	□ Alzheimer's □ Other
Surgical History	□ Gallb	ladder - Chole	cystectomy Apper	dectomy Hy	sterectom	y □ Bypass - CABG
	□ Heart	Stent □ He	ernia - Herrniorhaphy	□ Tonsilectomy	v □ Pros	tatectomy □ Other

Medications - Please provide list if additional space is needed.

Neurologic

Respiratory

Eye Medications

Medication	Strength	Frequency	Medication	Strength	Frequency & Eye
Allergies To Me	dications			No Known	Drug Allergies
	edication Allergies and Sy	mptoms:			
	,				
Family History					
	-		e family relationship for any	-	-
			se list the family relationship		
			_ □ Heart Disease/Relation	-	-
			□ Kidney Disease/Relati		
Social History					
•	gle □ Married □ Divo	rced □ Separated □	u Widow □ Unknown		
Do you Smoke	□ Every Day □ So	omeday Former	Smoker □ Never Smoked		
Do you drink Alcohol	□ None □ O	ccasional/Social	1 to 2 Drinks per day \Box	3 to 4 Drink	s per day
Do you have a history of	of substance abuse \square N	o □ Yes If Yes ple	ase explain:		
Occupation Ret	ired Home Mak	ter 🗆 Other			
Review of Symp	otoms Please check	x the box below if you h	ave any of the following sy	mptoms	•
			Teet □ Shortness of Breath		
Constitutional Fev	ver □ Weight Loss □ F	atigue Loss of Appe	etite 🗆 No Fevers, Fatigue,	or Weight I	Loss
Endocrine	cess Thirst Excessive	Urination □ Heat Intol	erance Cold Intolerance	Review	wed By:
Gastrointestinal Dia	arrhea	n □ Nausea		Physic	cian's Signature:
Genitourinary 🗆 Pai	n/Burning on Urination	□ Blood in Urine			
Hematology \Box Eas	sy Bruising 🗆 Prolonged	Bleeding Surgical:	Blood Transfusion in the F	Past Date:	
HENT □ Run	nny Nose □ Hearing Los	ss Sore Throat		Date.	
Integumentary Ras	sh □ Change in Mole				
Musculoskeletal □ Mu	scle Aches	□ Difficulty Laying F	lat due to Musculoskeletal I	Discomfort	

□ Tremor □ Dizziness □ Paralysis of Extremities □ Weakness □ Headaches □ Scalp Tenderness

 $\hfill \Box$ Wheezing $\hfill \Box$ Cough $\hfill \Box$ Coughing Blood $\hfill \Box$ No Cough or Wheezing



Identifying Information & Privacy Options

Identifying Information - Southeastern Retina Associates is now required to collect the following information from all of our patients.

Please check the	appropriate l	boxes below.	
Preferred Language	□ English	□ Other:	
Ethnicity	□ Hispanic	□ Not Hispanic or Latin	no 🗆 Unknown
Race	□ America	n Indian or Alaskan Nativo	e 🗆 Asian
	Black or	African American	□ Native Hawaiian/
	□ White	□ Other Race	other Pacific Islander
hours to discuss tes questions below wil May we leave a mes	t results, future Il give us guida ssage, either on	e appointments and according when we cannot co	ble to reach our patients during work count balances. Your response to the ntact you personally. ine or with the person answering your
home phone, regard	ding appointme	ents?	
□ YES □	NO		
May we speak with rangements?	other people r	egarding your insuranc	ce, billing questions or financial ar-
□ YES □	NO		
If yes, to whom may w	e speak?		
May we speak with	other people r	egarding test results or	other medical information?
	NO		
If yes, to whom may w	ve speak?		
My signature below indicat	tes that I have read a	copy of the Privacy Policy from	a Southeastern Retina Associates, PC.
Signature:			Date:



Diseases and Surgery of the Retina and Vitreous

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow your doctor to get a better view of the inside of your eye.

Dilating drops frequently 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 much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. Depending on your condition, your doctor may dilate one or both eyes. However, your doctor will typically dilate both eyes and you should therefore anticipate that both of your eyes will be dilated at every visit.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize my physician with Southeastern Retina Associates and/or such Southeastern Retina Associates' assistants as may be designated by him/her to administer dilating eye drops.

Patient (or person authorized to sign for patient)	Date	
Witness		



NOTICE OF PRIVACY PRACTICES Acknowledgement of Receipt

PLEASE REVIEW CAREFULLY

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices to review and have therefore been advised of how certain health information about me may be used and disclosed by **Southeastern Retina Associates (SERA)** and how I may obtain access to and control this information. I also acknowledge and understand that I may request a hard copy or copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and certain reproductive health information, and that it will be provided to me if I do request it.

Patient's signature	Date
Legal or Personal Representative of Patient (if applicable)	Relationship

This document is available in other languages and alternative formats that meet the guidelines for the Americans with Disabilities Act (ADA). Contact *SERA*

Effective Date: 7-1-2014

Pharmacy Information

Patient	
Name:	
Pharmacy	
Name:	
Pharmacy	
Address:	
Pharmacy	
Phone:	