SOUTHEASTERN RETINA ASSOCIATES

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.

Dear Patient:

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: _____

Appointment Time: _____

Appointment Location:_____

Patient Demographics

SOUTHEASTERN RETINA ASSOCIATES

Which doctor are you seeing today? _____

Patient's Name: _____ **Responsible Party:** _____

Address: _____ **Zip:** _____ **City:** _____ **State:** _____

Sex: □ Male □ Female **Title** □ Mr. □ Mrs. □ Miss □ Other _____

Phone: □ Home _____-_____-_____ □ Work _____-_____-_____ □ Cell _____-_____-_____

Please check the box for the phone number above that you would like us to use as your primary contact.

E-mail: _____ **Marital Status:** □ Single □ Married □ Divorced □ Widow □ Unknown

Date Of Birth: ____/____/_____ **Social Security #** _____-_____-_____ **Employer:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Patient's Employer: _____ **Primary Insurance Name:** _____

If you have insurance through through someone else:

Subscriber Name: _____ **Subscriber Date of Birth** ____/____/_____

Subscriber's Employer: _____

What Physician referred you to us? NAME & ADDRESS: _____

Primary Care Physician? NAME & ADDRESS: _____

Responsible Party if patient is a Minor:

Name: _____ **Address:** _____ **Phone:** _____-_____-_____

Relationship: _____ **Date of Birth:** _____/_____/_____ **SSN:** _____-_____-_____

Employer: _____ **Work Phone:** _____ **Cell:** _____

Spouse's Name: _____ **Spouse's SSN#:** _____

Spouse's Employer: _____ **Spouse's Work Phone:** _____

Spouse's Date of Birth: _____/_____/_____ **Spouse's Cell Phone:** _____

Is your visit related to an accident? □ Yes □ No **Will this be covered under Worker's Compensation?** □ Yes □ No

I authorize the disclosure of my personal health information to my referring physician, primary care physician, and insurance company, if applicable, via the use of written or fax transmittal, to carry out treatment, payment, or health care operations (TPO). I accept full financial responsibility for services rendered by Southeastern Retina Associates, PC., and agree to pay all reasonable collection costs and attorney fees in the event of default of payment on my charges. I further authorize and request insurance payments be made directly to Southeastern Retina Associates, PC should they elect to receive such payment. My signature below indicates that I have read and fully understand the forth written authorization. **Signature:** _____ **Date:** _____

MEDIGAP (SIGNATURE ON FILE STATEMENT FOR MEDICARE TO CROSSOVER TO 2ND INSURANCE)

Name of Beneficiary _____ **HICN** _____ **Medigap Policy Number** _____

I request that the payment of authorized Medigap benefits be made either to me or on my behalf to Southeastern Retina Associates, PC for any services furnished me by the provider. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits or the benefits payable for related services. **Beneficiary Signature:** _____ **Date:** _____

My signature below indicates that a copy of The Privacy Policy for Southeastern Retina Associates, PC has been made available to me.

Signature: _____ **Date:** _____

MEDICAL AND OCULAR

SOUTHEASTERN RETINA ASSOCIATES, P.C.

Diseases and Surgery of the Retina and Vitreous

SERA MD _____

Account # _____

Patient Name: _____ **Sex:** _____ **Age:**_____ **Date:** _____

Eye Doctor (Not Retina):_____ **City or Address:** _____

Medical Doctor: _____ **City or Address:** _____

Please answer the following questions to the best of your ability.

Give dates, a brief description, and which eye was involved to any **yes** question.

Present Illness Please describe your current eye problem: _____

_____

Ocular History **Have you ever had any of the following:**

Cataracts □ Right Eye □ Left Eye □ No **Cataract Surgery** □ Right □ Left Surgeon and Date: _____

Macular Degeneration □ Yes □ No **Glaucoma** □ Yes □ No **Retinal Detachment** □ Yes □ No

Eye Injury □ Yes □ No If yes, please explain _____

Any history of lazy eye, patching, or muscle surgery as a child? □ Yes □ No **Other Eye Problems**: _____

Medical History

Have you ever had any of the following…..

Seasonal Allergies □ Yes □ No **Food Allergies** □ Yes □ No Please List: _____

High Blood Pressure □ Yes □ No Controlled with medication □ Yes □ No

Heart Problems □ Yes □ No □ Heart Attack □ Angina □ Rhythm Problems □ Congestive Failure
□ Other _____

Neurology □ Yes □ No □ Stroke □ Seizures □ Migraine □ Tremors
□ Parkinson's □ Neuropathy □ Bells Palsy □ Mini Stroke (TIA)

Endocrine □ Yes □ No □ Diabetes _____How Long? _____ Last Blood Sugar
□ Type 1 □ Type 2
□ Thyroid □ Sarcoidosis _____ Last A1C Hemoglobin

Pulmonary □ Yes □ No □ Asthma □ Emphysema □ Lung Disease □ COPD □ Phlebitis
□ Tuberculosis □ Shortness of Breath □ Pneumonia □ Bronchitis

Genitourinary □ Yes □ No □ Prostate □ Kidney Disease □ Kidney Stones □ UTI

Gastroenterology □ Yes □ No □ GERD –reflux □ IBS □ Ulcers □ Hiatal Hernia
□ Acid Reflux □ Diverticulitis □ Crohn's Disease

Hematology □ Yes □ No □ Anemia □ Lupus □ Hepatitis □ High Cholesterol
□ HIV □ Sickle Cell Disease □ Lyme Disease
□ Cancer □ Skin □ Breast □ Prostate □ Lung □ Other _____

Rheumatology □ Yes □ No □ Arthritis □ Sjogren's Syndrome □ Rheumatoid Arthritis

Psychiatry □ Yes □ No □ Depression □ Anxiety □ Dementia □ Alzheimer's □ Other _____

Surgical History □ Gallbladder - Cholecystectomy □ Appendectomy □ Hysterectomy □ Bypass - CABG
□ Heart Stent □ Hernia - Herrniorhaphy □ Tonsilectomy □ Prostatectomy □ Other _____

Medications - Please provide list if additional space is needed.

Medication	Strength	Frequency

Eye Medications

Medication	Strength	Frequency & Eye

Allergies To Medications

☐ No Known Drug Allergies

□ Yes Please List Medication Allergies and Symptoms: _____

Family History

Is there an eye disease/problem which runs in your family? Please list the family relationship for any eye disease/problem you select.

□ Macular Degeneration /Relationship_____ □ Retinal Detachment /Relationship_____

□ Glaucoma/Relationship_____ □ Cataracts/Relationship_____

Is there any significant medical disease which runs in your family? Please list the family relationship for any medical disease you select.

□ High Blood Pressure/Relationship_____ □ Heart Disease/Relationship_____

□ Lung Disease/Relationship_____ □ Kidney Disease/Relationship_____

□ Cancer/Relationship_____ □ Diabetes/Relationship_____

Social History

Marital Status □ Single □ Married □ Divorced □ Separated □ Widow □ Unknown

Do you Smoke □ Every Day □ Someday □ Former Smoker □ Never Smoked

Do you drink Alcohol □ None □ Occasional/Social □ 1 to 2 Drinks per day □ 3 to 4 Drinks per day

Do you have a history of substance abuse □ No □ Yes If Yes please explain: _____

Occupation □ Retired □ Home Maker □ Other _____

Review of Symptoms

Please check the box below if you have any of the following symptoms…..

Cardiovascular □ Chest Pain □ Shortness of Breath □ Swelling of Feet □ Shortness of Breath when Laying Flat

Constitutional □ Fever □ Weight Loss □ Fatigue □ Loss of Appetite □ No Fevers, Fatigue, or Weight Loss

Endocrine □ Excess Thirst □ Excessive Urination □ Heat Intolerance □ Cold Intolerance

Gastrointestinal □ Diarrhea □ Abdominal Pain □ Nausea

Genitourinary □ Pain/Burning on Urination □ Blood in Urine

Hematology □ Easy Bruising □ Prolonged Bleeding **Surgical:** □ Blood Transfusion in the Past

HENT □ Runny Nose □ Hearing Loss □ Sore Throat

Integumentary □ Rash □ Change in Mole

Musculoskeletal □ Muscle Aches □ Joint Pain □ Difficulty Laying Flat due to Musculoskeletal Discomfort

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

Respiratory □ Wheezing □ Cough □ Coughing Blood □ No Cough or Wheezing

Reviewed By:

Physician's Signature:

_____

Date: _____

SOUTHEASTERN RETINA ASSOCIATES

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 boxes below.

Preferred Language □ English □ Other: _____

Ethnicity □ Hispanic □ Not Hispanic or Latino □ Unknown

Race

□ American Indian or Alaskan Native □ Asian

□ Black or African American □ Native Hawaiian/

□ White □ Other Race other Pacific Islander

Privacy Options - In some cases, it is not possible to reach our patients during work hours to discuss test results, future appointments and account balances. Your response to the questions below will give us guidance when we cannot contact you personally.

May we leave a message, either on your answering machine or with the person answering your home phone, regarding appointments?

□ YES □ NO

May we speak with other people regarding your insurance, billing questions or financial arrangements?

□ YES □ NO

If yes, to whom may we speak? _____

May we speak with other people regarding test results or other medical information?

□ YES □ NO

If yes, to whom may we speak? _____

My signature below indicates that I have read a copy of the Privacy Policy from Southeastern Retina Associates, PC.

Signature: _____ **Date:** _____

SOUTHEASTERN RETINA ASSOCIATES

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

SOUTHEASTERN RETINA ASSOCIATES

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:_____