Retina & Macula Consultants, PA Pt. #_______________

Age__________ DOB______________ Male__________ Female ___________ Race________ Marital Status S M W

Name: Mr. Mrs. Miss Dr. ____
Last First Middle

Phonetic spelling_________________________________ Spouse ____

E-Mail ____________________________ Home phone #_____________________ Cell # ______________________

Local Address _____________________________________ City ___________________ State ______ Zip ________

Northern Address _________________________________ City ___________________ State ______ Zip _______

Work phone ______________________________ Other phone/Northern # _________________________________

Occupation: ____ S.S. # _________________________________

PLEASE BRING YOUR INSURANCE CARDS AND PHOTO ID WITH YOU TO YOUR APPOINTMENT

ONGOING MEDICAL PROBLEMS-PLEASE CHECK YES OR NO

YES/NO			YES/NO		
□	□	Diabetes	□	□	Lung Disorder
□	□	Hypertension	□	□	Asthma
□	□	Heart Attack	□	□	Cancer
□	□	Heart Failure	□	□	Kidney Disorder
□	□	Irregular Rhythm	□	□	Ulcer
□	□	Stroke	□	□	Bleeding Disorder
□	□	Thyroid	□		Other__________
□	□	Arthritis – Osteo			________________________
□	□	Arthritis – Rheumatiod			

SURGERIES-PLEASE CHECK ALL THAT APPLY

□ Breast	□ Lung
□ Heart	□ Eye _________________
□ Hysterectomy	_________________
□ Carotid	_________________
□ Gall Bladder	□ Other_________________

PROBLEMS WITH PREVIOUS SURGERY/ANESTHESIA □YES □NO

Describe:____
____
____
____

CURRENT MEDICINES

PLEASE BRING A LIST OF ALL MEDS

1. ______________________ 5. _____________________
2. ______________________ 6. _____________________
3. ______________________ 7. _____________________
4. ______________________ 8. _____________________

ALLERGIES/DRUG REACTIONS

____
____
____
____
____

Family Eye History: □Glaucoma □Retinal Detachment □Macular Degeneration ________________________

Social: Lives with □Alone □Spouse □Care Center □Other □Smoke _________per day □Alcohol Use
Hobbies/Activities ____
Emergency Contact _________________________ Relationship _______________ Phone_____________

I UNDERSTAND THAT PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED. I HAVE READ THE ABOVE INFORMATION AND BELIEVE IT TO BE TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

____ ___________________________
Signature PLEASE SIGN AND DATE Date

Ref By: ____