

**\*\*\* Please complete ALL forms using BLACK ink \*\*\***

*Appointment Date* \_\_\_\_\_ *Appointment Time* \_\_\_\_\_

*Scheduled with Dr.* \_\_\_\_\_ *Office Location* \_\_\_\_\_

Dear New Patient,

We appreciate your selection of our office for the care of your retinal (eye) condition. First visits to our office usually take approximately two to three hours. Dilation of your eyes will be required for the examination. Since the effect of this procedure can take a few hours to wear off, you will not be able to drive home afterwards. Therefore, we recommend that you arrange for other means of transportation to return home following your appointment. Please bring someone to drive you home or plan alternate arrangements.

Prior to your appointment, please fill in the new patient forms attached. Either bring these forms with you to your appointment, or plan to arrive at least twenty minutes before your scheduled appointment time to complete them in our office. Also, please bring a list of any medications and eye drops that you are currently using, along with your eyeglasses or contact lenses. Be sure you have all of your insurance cards and a current driver's license or other photo identification with you when you come to the office. We will ask for these cards and will keep a copy of each in our medical record.

We will file Medicare, Medicaid, Blue Cross, Blue Advantage, Aetna, Cigna, HealthSpring, United HealthCare, Viva, and all other insurances for you. Applicable co-payments will be collected from you for all insurance plans with which we participate. Payment is requested at the time of the office visit for any co-payments or non-insurance service and may be made in cash or by check or credit card. If you have not met your annual insurance deductible, all or a portion of that amount will be required at your visit as well.

If your insurance company requires that you get a referral (permission to be treated by one of our doctors), you are responsible for contacting your primary care physician (family doctor) before you come to our office. We suggest you call your primary care physician as soon as an appointment date has been set.

If you do not have health insurance, please contact our Billing Office at (205)329-7100 or (800)575-4315 at least TWO business days prior to your scheduled appointment to discuss payment options for our services.

We look forward to seeing you. If you have any questions regarding your appointment, please call us at (205)918-0047 or (800)575-4314. For billing and/or insurance information, please contact one of our Billing Office Representatives at (205)329-7100 or (800)575-4315. Thank you for your confidence in allowing us to participate in your retina care. We look forward to meeting you soon.

Most sincerely,

*The Physicians and Staff of Retina Consultants of Alabama, P.C.*

**PATIENT DEMOGRAPHIC INFORMATION**

Account Number \_\_\_\_\_

Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_  Male  Female

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

I authorize Retina Consultants of Alabama to leave messages for me concerning my appointments and eye care.

Email Address \_\_\_\_\_

Social Security Number \_\_\_\_\_ Patient's Date of Birth \_\_\_\_\_

*If Nursing Home/Assisted Living/Rehab resident, Name of Facility* \_\_\_\_\_

Facility Phone: (\_\_\_\_) \_\_\_\_\_ Room Number \_\_\_\_\_

Employment  Full-Time  Part-Time  Not Employed  Retired  Minor/Child

*If employed, Place of Employment* \_\_\_\_\_ *Occupation* \_\_\_\_\_

Type(s) of Insurance \_\_\_\_\_

Marital Status  Single  Divorced  Widowed  Married

*If married, Spouse's Name* \_\_\_\_\_

Spouse's Date of Birth \_\_\_\_\_

*If patient is a minor, Mother's Name* \_\_\_\_\_

Mother's Date of Birth \_\_\_\_\_

Father's Name \_\_\_\_\_

Father's Date of Birth \_\_\_\_\_

Legal Guardian's Name \_\_\_\_\_

Relationship \_\_\_\_\_

*(if different than Mother or Father)*

**EMERGENCY CONTACTS (Persons NOT living in your home; i.e. relatives or friends)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Referring Physician \_\_\_\_\_

Person(s) to Whom Medical Information May Be Released \_\_\_\_\_

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance at the time of your examination.**

2. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

3. This assignment will remain in effect until revoked by me in writing. A photocopy or digital image of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. In the event of default in the payment of my charges, I agree to pay all costs of collections, including reasonable attorney's fees if applicable.

X  
\_\_\_\_\_  
*Patient's/Legal Guardian's Signature (must be 18 years of age or older)*

\_\_\_\_\_  
*Date*

## MEDICARE LIFETIME AUTHORIZATION

\_\_\_\_\_  
*Patient's Name*

\_\_\_\_\_  
*Account Number*

I request the payment of authorized Medicare benefits be made either to me or on my behalf to Retina Consultants of Alabama, P.C. (Drs. Richard M. Feist, John O. Mason, III, Michael A. Albert, Jr., Jason N. Crosson, Richard M. Feist, Jr., Richard M. Martindale, and/or other affiliated physicians) for any services furnished to me by that provider of care. I authorize any holder of medical information about me to release to the Center of Medicare Services and its agents, any information needed to determine these benefits or the benefits payable for related services.

X

\_\_\_\_\_  
*Patient's / Legal Guardian's Signature*

\_\_\_\_\_  
*Date*

## CONSENT FOR TREATMENT/FINANCIAL AGREEMENT

\_\_\_\_\_  
*Patient Name*

\_\_\_\_\_  
*Account Number*

I consent to treatment necessary or desirable to the care of the patient first mentioned above, including but not restricted to, whatever drugs, medicine, performance of operation that may be used by the attending doctor, his nurse, or qualified designate. I also acknowledge full responsibility for the payment of all services. I understand that the patient or responsible party is solely responsible for payment of all services, though the insurance may be filed. If this account becomes delinquent, I agree to pay all costs of collection, including a reasonable attorney's fee.

I understand that some services are not always covered as dictated by my insurance company based on the medical necessity. I understand that if any treatment is rejected by my insurance plan as a non-covered procedure that I will be billed for those services. I also acknowledge as a member of these plans, that my insurance will be submitted by this office and I will be responsible for paying all copays and/or deductibles at the time of visit.

I understand that if my insurance is an HMO, that I must obtain a referral from my Primary Care Physician every visit before coming to this office for any appointments. I understand that it is my responsibility as the patient to confirm that my referral is current and in effect when I arrive for my appointment. If no referral is obtained, I will pay for the visit.

I authorize my insurance company to remit payment of medical benefits directly to this office for services provided by our physicians.

I hereby authorize the release of all medical records on the patient listed above to the referring and family physicians, as well as all records necessary for the processing of insurance claims.

X \_\_\_\_\_  
*Patient's / Legal Guardian's Signature*

\_\_\_\_\_  
*Date*

## **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE**

\_\_\_\_\_  
*Patient Name*

\_\_\_\_\_  
*Account Number*

I understand that Retina Consultants of Alabama is part of an organized healthcare arrangement, and that these providers may share my health information for treatment, billing, healthcare operations, and research purposes. I have been given a copy of their Notice of Health Information Practices that describes how my health information is used and shared. I understand that Retina Consultants of Alabama has the right to change this notice at any time. I may obtain a current copy by contacting the office.

My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Health Information Practices.

X \_\_\_\_\_  
*Patient's/Legal Guardian's Signature*

\_\_\_\_\_  
*Date*

## **DILATING EYE DROPS**

\_\_\_\_\_  
*Patient Name*

\_\_\_\_\_  
*Account Number*

**Please read this important information carefully:**

Dilating eye drops are used to enlarge (dilate) the pupil of the eye to allow the ophthalmologist (eye doctor) to view the inside of the eye and perform a thorough examination of the retina. The retina cannot be completely observed without the use of these drops.

Dilating drops usually blur the vision for a length of time that varies from person to person (up to several hours) and may make bright lights bothersome. It is not possible for your doctor to predict how much your vision will be affected. Driving must be avoided immediately following your examination and you should not drive until the effects of the dilating drops have worn off.

By signing below, you acknowledge an understanding that dilating drops will be used in your eyes at this visit and **EACH** future appointment you may have at Retina Consultants of Alabama. Further, you understand that another person must be available at all visits to drive you home.

X \_\_\_\_\_  
*Patient's / Legal Guardian's Signature*

\_\_\_\_\_  
*Witness' (Staff Member's) Signature*

\_\_\_\_\_  
*Date*

Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Date: \_\_\_\_\_

**MEDICAL INFORMATION**

PHYSICIANS (name, address/location, telephone number)

Ophthalmologist/Optomtrist (eye):

Primary Care (family):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 ( ) \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 ( ) \_\_\_\_\_

Cardiologist (heart):

Other (i.e., Endocrinologist, etc.):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 ( ) \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 ( ) \_\_\_\_\_

PHARMACY

Name: \_\_\_\_\_  
 Location: \_\_\_\_\_  
 Telephone: ( ) \_\_\_\_\_

MEDICATION

List of medicines you take regularly and dosages/schedule (including eye drops):

See attached list

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Allergies to medicines: \_\_\_\_\_

Type of reaction: \_\_\_\_\_

Please check YES or NO as to whether you are taking or have ever taken the following medications.

	YES	NO
Plaquenil or Plaquenil Sulfate (hydroxychloroquine)	_____	_____
Soltamox (tamoxifen)	_____	_____
Mellaril (thioridazine)	_____	_____
Topamax, Topamax Sprinkle, or Topiragen (topiramate)	_____	_____
Elmiron (pentosan polysulfate)	_____	_____

Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Date: \_\_\_\_\_

**PAST EYE HISTORY** (where appropriate, list dates and which eye involved)

Known eye diseases: \_\_\_\_\_

Previous eye operations/dates: \_\_\_\_\_

Previous eye injuries/dates: \_\_\_\_\_

**PAST MEDICAL HISTORY**

Medical Conditions

Diabetes                                    Y    N    If yes, how long? \_\_\_\_\_

High blood pressure                    Y    N    \_\_\_\_\_

Heart disease                            Y    N    If yes, explain: \_\_\_\_\_

Other major illnesses (please list): \_\_\_\_\_

Previous surgeries (other than eye): \_\_\_\_\_

**FAMILY HISTORY** (list blood relatives only)

If **YES**, relationship to patient?  
 (M=mother, F=father, S=sibling, GP=grandparent)

Retinal detachment	Y	N	_____
Age-related macular degeneration	Y	N	_____
Blindness	Y	N	_____
Glaucoma	Y	N	_____
Arthritis	Y	N	_____
Cancer	Y	N	_____
Diabetes	Y	N	_____
Heart disease/high blood pressure	Y	N	_____
Kidney disease	Y	N	_____
Lupus	Y	N	_____
Stroke	Y	N	_____

**SOCIAL HISTORY**

Occupation: \_\_\_\_\_

Marital status:  Single     Divorced     Widowed     Married

Special living arrangements:  Wheelchair     Ambulatory with Assistance     Non-Ambulatory

Do you drive?                            Y    N

Do you drink alcohol?                    Y    N    If **YES**:  occasional     1/day     2-3/day     4+/day

Do you currently smoke?                Y    N    If **YES**:  occasional     ½ pack/day     1+pack/day

    If **NO**, have you ever smoked?    Y    N    If **YES**: number of years? \_\_\_\_\_ when did you quit? \_\_\_\_\_

Do you currently use smokeless  
 or other tobacco products?            Y    N    If **YES**: number of years? \_\_\_\_\_



Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Date: \_\_\_\_\_

**REVIEW OF SYSTEMS**

Please check YES or NO as to whether you have ever had the following symptoms/problems.

	YES	NO
<b>ENDOCRINE SYSTEM</b>		
Frequent urination, frequent thirst and hunger.....	_____	_____
Diabetes mellitus.....	_____	_____
<input type="checkbox"/> Diet-controlled <input type="checkbox"/> Diet plus oral medicine		
<input type="checkbox"/> Diet and insulin      Insulin type and dose _____		
Last hemoglobin A1C measurement and date _____		
Thyroid disease.....	_____	_____
<input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hyperthyroid		

<b>HEART/BLOOD VESSELS</b>		
Hypertension.....	_____	_____
Valvular heart disease.....	_____	_____
Coronary artery disease.....	_____	_____
Arrhythmia (irregular heartbeat).....	_____	_____
Congestive heart failure.....	_____	_____
Difficulty breathing while at rest.....	_____	_____
Chest pain on exertion.....	_____	_____
Fluid accumulation in feet/ankles.....	_____	_____
Heart bypass surgery.....	_____	_____
Pacemaker.....	_____	_____
Defibrillator implant device.....	_____	_____
Other heart problems, explain _____	_____	_____
Exercise tolerance <input type="checkbox"/> Sedentary only <input type="checkbox"/> 2-3 flights of stairs		
<input type="checkbox"/> Normal activities <input type="checkbox"/> Aerobic exercise		

<b>CANCER</b>		
History of cancer.....	_____	_____
Type_____		
Treatment _____		

<b>NERVOUS SYSTEM</b>		
Stroke.....	_____	_____
Temporary weakness of part of the body.....	_____	_____
Temporary difficulty speaking.....	_____	_____
Seizures.....	_____	_____
Generalized muscle weakness.....	_____	_____
History of anxiety or panic attacks.....	_____	_____
History of schizophrenia.....	_____	_____

<b>BONE/JOINT</b>		
Chronic lower back pain.....	_____	_____
Arthritis, type _____	_____	_____
Cervical spine diseases.....	_____	_____

Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Date: \_\_\_\_\_

<b>BLOOD/LYMPH</b>	<b>YES</b>	<b>NO</b>
Anemia.....	_____	_____
Sickle cell disease.....	_____	_____
Sickle cell trait.....	_____	_____
Thalassemia .....	_____	_____
Hemoglobin C disease .....	_____	_____
Bleeding problems (free bleeder) .....	_____	_____
HIV .....	_____	_____
Other blood disorders, explain _____	_____	_____
 <b>LUNGS/BREATHING</b>		
Active asthma .....	_____	_____
Asthma in the past .....	_____	_____
Productive cough within the last month .....	_____	_____
Chronic bronchitis .....	_____	_____
Other breathing problems, explain _____	_____	_____
 <b>STOMACH/INTESTINES</b>		
Reflux from stomach .....	_____	_____
Ulcer disease .....	_____	_____
Liver disease .....	_____	_____
Hepatitis .....	_____	_____
History of nausea and vomiting .....	_____	_____
Gall bladder disease .....	_____	_____
Blood in vomit .....	_____	_____
Rectal bleeding .....	_____	_____
 <b>KIDNEY/URINARY</b>		
Renal failure .....	_____	_____
On dialysis .....	_____	_____
Kidney transplant .....	_____	_____
Current urinary infection .....	_____	_____
History of kidney stones .....	_____	_____
History of blood in urine .....	_____	_____
 <b>SKIN</b>		
History of skin cancer .....	_____	_____
Use of oral tanning agents .....	_____	_____
Use of oral retinoic acid for acne .....	_____	_____
Other skin problems, explain _____	_____	_____

\_\_\_\_\_  
*Technician Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Physician Signature*

\_\_\_\_\_  
*Date*