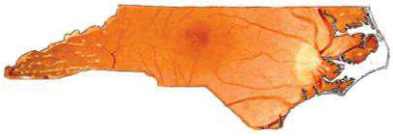
www.RIofNC.com

CHART #_____



RETINA INSTITUTE OF NORTH CAROLINA, PC

PATIENT DATA SUMMARY

PATIENT LEGAL NAME _____ DATE _____

SOCIAL SECURITY NUMBER _____ Marital Status **S M D W**

DATE OF BIRTH _____ Gender **M** or **F**

HOME ADDRESS _____ HOME TELEPHONE (_____)_____

CITY _____ STATE _____ ZIP _____ CELL PHONE (_____)_____

OCCUPATION _____ EMPLOYER _____

WORK ADDRESS _____ WORK TELEPHONE (_____)_____

CITY _____ STATE _____ ZIP _____

Who referred you to our office? _____

PRIMARY CARE PHYSICIAN CONTACT INFORMATION:

PRIMARY CARE PHYSICIAN **(PCP)** _____ NAME OF FACILITY _____

PCP ADDRESS _____ TELEPHONE NUMBER _____

INFORMATION OF THE PERSON RESPONSIBLE FOR THE COVERAGE:

Policy Holder's Name _____ **Effective Date _____**

RELATIONSHIP TO PATIENT _____ POLICY HOLDER'S DOB _____

HOME ADDRESS _____ HOME TELEPHONE _____

CITY _____ STATE _____ ZIP _____ WORK TELEPHONE _____

PLEASE PROVIDE THE RECEPTIONIST WITH YOUR MOST CURRENT INSURANCE CARD(S) & PHOTO ID.

EMERGENCY CONTACT: _____ **Relationship to patient: _____**

HOME ADDRESS _____ HOME TELEPHONE _____

CITY _____ STATE _____ ZIP _____ CELL PHONE _____

Authorization: I authorize Retina Institute of North Carolina, PC to furnish information to my insurance carrier(s) concerning this service. I irrevocably assign to the Retina Institute of North Carolina all payments for medical service rendered. I understand that I am financially responsible for all charges regardless of whether they are covered by my insurance carrier(s). I will pay for office visit charges at the time of service. Section 1862 (A)(1) of the Medicare law limits payment of benefits in only those services that are "reasonable and necessary." If Medicare finds that any particular service is not reasonable and necessary, even though it would otherwise be covered, it will deny payment for that service.

Signature of Responsible Party: _____ Date: _____

RETINA INSTITUTE OF NORTH CAROLINA, PC

OFFICE AND PAYMENT POLICIES

1. It is the patient's responsibility to know and understand your medical insurance benefits. If your insurance requires a referral, you will be responsible for obtaining the proper referral. Please let our office know when there are any changes in insurance, address, phone number, etc.
2. **Your copay and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-pays and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-pay/balance each visit.**
3. Please be aware that some of the services you receive may be non-covered by Medicare or other insurers. You will be responsible for these services.
4. Appointments begin promptly at your assigned time. If you are 10+ minutes late, we may ask you to reschedule.
5. Please allow at least 24 hours for prescription refills and call returns.
6. **Please give our office a 24 hour notice if you unable to keep your appointment or need to reschedule.**
7. If you do not show for your appointment or you cancel less than 24 hours from your scheduled time, there will be a $25.00 fee charged to your account.
8. Please allow up to 30 days to process medical record requests and any forms that need to be completed for disability claims, insurance companies or work.

I have read and understand the office and payment policies. I agree to abide by its guidelines.

Patient signature: _____ Date: _____

RETINA INSTITUTE OF NORTH CAROLINA, PC

RELEASE OF MEDICAL INFORMATION

PLEASE PRINT YOUR LEGAL NAME: _____

BY SIGNING BELOW, I AUTHORIZE RETINA INSTITUTE OF NORTH CAROLINA, PC, TO RELEASE MY MEDICAL AND BILLING INFORMATION TO:

RELATIONSHIP			**NAME OF DESIGNATED PERSON**
SPOUSE	□ YES	□ NO	_____
CHILDREN	□ YES	□ NO	_____
IN-LAWS	□ YES	□ NO	_____
CAREGIVERS	□ YES	□ NO	_____
PARENTS	□ YES	□ NO	_____

OTHERS _____ **RELATIONSHIP TO PATIENT _____**

We ask if you have any change in this request that you please inform the receptionist.

RETINA INSTITUTE OF NORTH CAROLINA, PC, MAY LEAVE APPOINTMENT INFORMATION ON MY VOICEMAIL:

HOME	□ YES	□ NO
CELL	□ YES	□ NO
WORK	□ YES	□ NO
RELATIVE	□ YES	□ NO

I AUTHORIZE THE FOLLOWING TO PICK UP PRESCRIPTIONS, X-RAYS, MEDICAL RECORDS, ETC…

RELATIONSHIP			**NAME OF DESIGNATED PERSON**
SPOUSE	□ YES	□ NO	_____
RELATIVE	□ YES	□ NO	_____
CAREGIVER	□ YES	□ NO	_____

OTHERS _____ **RELATIONSHIP TO PATIENT _____**

PATIENT SIGNATURE _____ DATE _____

I UNDERSTAND THAT THE RETINA INSTITUTE OF NORTH CAROLINA, PC, WILL ASK FOR IDENTIFICATION OF THE PERSON PICKING UP PATIENT MEDICAL INFORMATION OR PRODUCTS.

RETINA INSTITUTE OF NORTH CAROLINA, PC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: _____

Signature: _____ Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason:

MEDICAL HISTORY • SYMPTOM • SURGICAL INFORMATION

NAME: _____ **DATE: _____**

SYMPTOMS:	
EYES:	loss of vision blurred vision fluctuated vision distorted vision loss of side vision double vision dryness mucus redness sandy or gritty feeling burning or itching foreign body sensation excess tearing/watering glare and light sensitivity eye pain or soreness
GENERAL:	fever weight loss fatigue
EARS, NOSE, THROAT:	hard of hearing ear ache cough dry mouth sinus/allergy hoarseness vertigo
GASTROINTESTINAL:	upset stomach diarrhea constipation
RESPIRATORY:	congestion wheezing short of breath TB exposure
GENITOURINARY:	painful/ frequent urination impotence yellow jaundice blood in urine
DERMATOLOGIC:	warts growths rash
ENDOCRINE:	increased thirst increased urination increased hunger
ALLERGIC/IMMUNOLOGIC:	sneezing swelling redness itching
CARDIOVASCULAR:	chest pain racing pulse irregular heartbeat heart palpitations
HEMATOLOGY:	bleeding
MUSCULOSKELETAL:	joint pain stiffness swelling
PSYCHIATRIC:	history of substance abuse anxiety depression insomnia
NEUROLOGICAL:	numbness headache seizures paralysis memory loss
FEMALES:	Are you pregnant? **YES** **NO** Are you nursing? **YES** **NO**

FAMILY HISTORY: Does any member **of your immediate family (blood relatives)** have these diseases?

Disease/Condition	**FAMILY MEMBER**	**Disease/Condition**	**FAMILY MEMBER**
Lazy Eye	Mother Father Sibling Grandparent	Diabetes	Mother Father Sibling Grandparent
Blindness	Mother Father Sibling Grandparent	Heart Disease	Mother Father Sibling Grandparent
Cataracts	Mother Father Sibling Grandparent	High Blood Pressure	Mother Father Sibling Grandparent
Glaucoma	Mother Father Sibling Grandparent	High Cholesterol	Mother Father Sibling Grandparent
Macular Degeneration	Mother Father Sibling Grandparent	Kidney Disease	Mother Father Sibling Grandparent
Retinal Disorders	Mother Father Sibling Grandparent	Lung Disease	Mother Father Sibling Grandparent
Arthritis	Mother Father Sibling Grandparent	Lupus	Mother Father Sibling Grandparent
Cancer	Mother Father Sibling Grandparent	Stroke	Mother Father Sibling Grandparent
Type of cancer: _____		Thyroid Disease	Mother Father Sibling Grandparent

SOCIAL HISTORY

Do you smoke?

☐ Current Everyday ☐ Current Some Days

☐ Former ☐ Never

How many packs of cigarettes per day? _____

Do you drink?

☐ Rarely ☐ Occasionally

☐ Socially ☐ Frequently

☐ Never

MEDICAL HISTORY • SYMPTOM • SURGICAL INFORMATION

DISEASES:	**Circle any and all conditions that apply to you** or circle none. **NONE**
EYES:	blindness cataracts diabetic retinopathy glaucoma macular degeneration retinal detachment lazy eye eye trauma amblyopia crossed eyes drooping eyelid
EARS, NOSE, THROAT:	allergic rhinitis vertigo seasonal allergies
GASTROINTESTINAL:	hernia peptic ulcer disease crohn's ulcerative colitis reflux (GERD)
RESPIRATORY:	asthma COPD emphysema chronic bronchitis
GENITOURINARY:	kidney stones kidney failure
DERMATOLOGIC:	acne eczema melanoma psoriasis rosacea cancer **(specify type)** _____
ENDOCRINE:	grave's disease thyroid disease hypoglycemia diabetes **(specify type)** Type1□ Type2□ Controlled□ Uncontrolled□ Insulin Dependent? Yes □ No □
ALLERGIC/IMMUNOLOGIC:	HIV+ lupus sjogren's syndrome rheumatoid arthritis herpes simplex virus hepatitis A/B shingles reiter's syndrome ankylosing spondylitis
CARDIOVASCULAR:	atrial fibrillation congestive heart failure heart attack heart arrhythmia high blood pressure high cholesterol
HEMATOLOGY:	anemia blood clot in lungs blood clot in legs low platelets
MUSCULOSKELETAL:	fibromyalgia multiple sclerosis arthritis carpal tunnel syndrome gout osteoporosis
PSYCHIATRIC:	anxiety depression bipolar disorder insomnia other _____
NEUROLOGICAL:	alzheimer's dementia parkinson's stroke autism bell's palsy epilepsy schizophrenia migraines

MEDICATION / ALLERGY INFORMATION

Eye Medications	Dosage	Frequency	**Eye Medications**	Dosage	Frequency
Systemic Medications	Dosage	Frequency	**Systemic Medications**	Dosage	Frequency

Please list all medication / food allergies that you have: (Please include reaction to allergy)

_____ _____

_____ _____

_____ _____

Eye Surgeries / Procedures	Date	Eye Surgeries / Procedures	Date
General Surgeries	Date	**General Surgeries**	Date

Primary Care Physician:

Name: _____

Phone #: _____

Address: _____

_____

Pharmacy Contact Information:

Name: _____

Phone #: _____

Address: _____

_____

Patient Signature: _____ **Date:** _____