Pt Acct #: ________________

Retinal Vitreal Consultants ~ Retina Macula Care

Patient Demographic Information

*Fields with * are required*

PATIENT INFORMATION

Last name*: ____________ First name*: ____________ Middle initial: ______

Nickname or Preferred Name: ____________

DOB*: ____________ Social Security#*: ____________ Gender*: ____________

Home address*: ____________ APT/Suite #: ____________

City*: ____________ State*: ____________ ZIP*: ____________

Home #*: ☐ ____________ Mobile #*: ☐ ____________ (Checkmark the best number to use)

Email address*: ____________

What are your pronouns: ☐ He/him ☐ She/her ☐ They/them ☐ Other: ____________

Do you think of yourself as:
☐ Male ☐ Female ☐ Transgender man/trans man ☐ Transgender woman/trans woman
☐ Genderqueer/gender nonconforming, neither exclusively male nor female
☐ A category not listed here, please specify: ____________ ☐ Decline to answer

Occupation: ____________

Employer Name: ____________

Work Phone #: ____________

Work Address: ____________ City: ____________ State: ______ ZIP: ______

LANGUAGE & DEMOGRAPHICS

Preferred language: ____________ Do you need an interpreter?: ____________

Ethnicity: ____________ Race: ____________

Marital Status: ____________

NAME OF SPOUSE/DOMESTIC PARTNER

Last name: ____________ First name: ____________ Middle initial: ______

IF THE PATIENT IS LIVING IN A NURSING OR ASSISTED LIVING FACILITY*

Name of Facility: ____________

Facility Address*: ____________ Room #*: ____________

City*: ____________ State*: ____________ ZIP*: ____________

Facility Phone #: ____________ Facility Contact Name: ____________

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PARENT/RESPONSIBLE PARTY INFO* (If info same as above, leave blank)

Last name*: ______________ First name*: ______________ Middle initial: ________

Social security #: ______________ Relationship to patient*: ______________

Address*: ______________ City*: __________ State*: ______ ZIP*: ______

Home #*: __________ Cell #*: __________ Email address*: ______________

PHARMACY*

Pharmacy Name*: ______________ Pharmacy Phone #*: ______________

Pharmacy Address: ______________ City: __________ State: ______ ZIP: ______

PATIENT REFERRAL/PCP INFORMATION			
Patient referred by*			Phone #*
Clinic Address*	City*	State*	ZIP*
Primary Care Physician (PCP) Name*			Phone #*
Clinic Address*	City*	State*	ZIP*

EMERGENCY CONTACTS (PLEASE PROVIDE TWO WITH DIFFERENT CONTACT INFORMATION)		
Name	Relationship	Phone #
Name	Relationship	Phone #

Billing & Insurance Information

INSURANCE INFORMATION	
Primary Insurance*	Subscriber Name/Relation*
Insurance ID# / Group # / Subscriber Date of Birthh	
Secondary Insurance*	Subscriber Name/Relation*
Insurance ID# / Group # / Subscriber Date of Birth	
Tertiary Insurance*	Subscriber Name/Relation*
Insurance ID# / Group # / Subscriber Date of Birth	

Pt Acct #: ___________________

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Financial Assignment and Agreement

1. Please remember that insurance is considered a method of reimbursement for the patient for fees charged by the doctor and is **NOT** a substitute for payment. Insurance does not usually pay the entire charge. Very often there are DEDUTIBLES, COPAYS AND CO-INSURANCE amounts that remain the patient's responsibility. **NON-COVERED SERVICES**: I understand that some services may be considered non-covered services by my insurance plan. I understand that it is my responsibility to know what my insurance does or does not cover, and I understand that I am financially responsible for paying all non-covered services. **DENIED CHARGES**: I understand that some charges may be denied by my insurance carrier as investigational, experimental or not medically necessary and will not be paid by my insurance carrier. I understand that my physician feels these services are needed whether my insurance carriers deems them payable or not, and that I am obligated to pay for these services in full.
2. **ALL OFFICE COPAYS ARE DUE AT THE TIME OF SERVICE**.
3. **IF YOU HAVE HMO INSURANCE**: It is **YOUR** responsibility to obtain a referral and/or authorization from your primary care physician for all visits and services including testing and treatment. **IF YOUR HMO/MANAGED CARE PLAN DENIES PAYMENT DUE TO LACK OF REQUIRED REFERRAL, YOU AGREE TO BE FULLY RESPONSIBLE FOR PAYMENT.**
4. An assignment of benefits is required to file insurance claims for you. Therefore, we ask that you agree to the following statement: I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any order of medical information about me be released to the Center for Medicare & Medicaid Services, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
5. This assignment will remain in effect until revoked by me in writing. A photocopy 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 insurance. I hereby authorize said assignee to release all information necessary to secure payment.
6. This office charges $25.00 for any missed appointment without a 24-hour cancellation notice.

Patient signature: ____ **Date:** ____________________
(or parent and/or legal guardian)

AUTHORIZED CONTACTS (Individuals authorized to inquire and speak on my behalf for ALL healthcare, insurance and billing issues)		
Name	**Relation**	**Phone #**
Name	**Relation**	**Phone #**
Name	**Relation**	**Phone #**
Name	**Relation**	**Phone #**

Pt Acct #: ___________________

Retinal Vitreal Consultants ~ Retina Macula Care

Acknowledgment of Receipt of Notice of Privacy Practices

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

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

I have received, read and understand the *Notice of Privacy Practices* document containing a more complete description of the uses and disclosures of my health information. I understand that Retinal Vitreal Consultants has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below for a current copy of the *Notice of Privacy Practices* document.

Do we have your permission to:

Leave a message on your answering machine?	☐ Yes	☐ No
Confirm appointments by leaving messages or speaking with family?	☐ Yes	☐ No
Send text message reminders? (standard text msg rates apply)	☐ Yes	☐ No

______________________	______________________	______________________
Patient name	**Signature**	**Date**
______________________	______________________	______________________
Name/relationship to patient	**Signature**	**Date**

FOR OFFICE USE ONLY

Data Entered into eCW by: ______________________________ **Date:** ______________

Practice provided the above-referenced patient with the Practice's Notice of Privacy Practices and this Acknowledgment of Receipt of Notice of Privacy Practices, but could not obtain a signed acknowledgment form because:

☐ Patient or guardian refused to sign

☐ Emergency situation

☐ Other: ______________________________

For patients requiring translation or verbal reading of the document, the reader or translator may document and sign below.

Reader/translator: ______________________________ **Date:** ______________

2600 S. Michigan Ave, Ste 212 Chicago IL 60616 ~ 4429 W. 95th St, Oak Lawn, IL 60453

Pt Acct #: ____________________

Retinal Vitreal Consultants ~ Retina Macula Care

Medical History Questionnaire

ALLERGIES: | **REACTION:** | **SEVERITY:**

________________________ ________________________ mild / moderate / severe

________________________ ________________________ mild / moderate / severe

PAST OCULAR HISTORY: **(Please mark all that apply)** __ No history of eye problems

__ Cataracts
__ Diabetic Retinopathy
__ Dry Eye
__ Glaucoma
__ Hyperopia (Far sighted)
__ Iritis
__ Keratoconus
__ Macular Degeneration
__ Myopia (Near sighted)
__ Optic Neuritis
__ Retinal Detachment
__ Amblyopia (Lazy eye)
__ Aphakia
__ Astigmatism

OCULAR SURGERIES: **(Please mark all that apply)** __ No prior ocular surgery

R	- L		R	- L		R	- L		R	- L	
__	__	Foreign Body Removal	__	__	Punctal Plugs	__	__	Laser	__	__	Cataract Surgery
__	__	Blepharoplasty	__	__	Retinal Laser Surgery	__	__	RK	__	__	LASIK/PRK
__	__	Strabismus Surgery	__	__	Vitrectomy	__	__	Corneal Transplant	__	__	Eye Muscle Surgery

OTHER MEDICAL HISTORY: __ No history of illnesses

__ Thyroid Disease
__ Anemia
__ Arthritis
__ Arrhythmia
__ Asthma
__ Bleeding Disorder
__ Cancer
__ Chicken Pox
__ Hepatitis A / B / C
__ Herpes Simplex
__ Congestive Heart Failure
__ COPD
__ Diabetes Type 1
__ Diabetes Type 2
__ Eczema
__ Fibromyalgia
__ Hearing Loss
__ Herpes Zoster / Shingles
__ Histoplasmosis
__ Syphilis
__ Headache
__ High Blood Pressure
__ High Cholesterol
__ HIV/AIDS
__ Kidney Disease
__ Kidney Stone
__ Liver Disease
__ Meningitis
__ MRSA
__ Lung Disease
__ Lupus
__ Migraine
__ Polymyalgia
__ Psychiatric Disorder
__ Skin Cancer
__ Stroke
__ Toxoplasmosis
__ Wound Infection

Other____

Are you currently pregnant? __ YES __ NO If yes, _____ Weeks Pregnant

CURRENT MEDICATIONS: **(Name & Dosage)**

________________________ ________________________ ________________________

________________________ ________________________ ________________________

________________________ ________________________ ________________________

FAMILY HISTORY:

__ Arthritis
__ Blindness
__ Cancer
__ High Blood Pressure
__ Diabetes
__ Glaucoma
__ Heart Disease
__Retinal Disease
__Kidney Disease
__ Lazy Eye
__ Macular Degeneration
__ Stroke
__ TB
__ Cataracts

SOCIAL HISTORY: **(Please mark all that apply)**

Smoking: __current daily smoker __current some days smoker __former smoker __ never smoked

Alcohol Use: __ Yes __ No If yes, how much and how often? ______________________________

Drug Use: __ Yes __ No If yes, what and how often? ______________________________