Retinal Consultants
Patient Registration

Please read carefully before completing form.

We expect an insurance form completed if indicated for your insurance coverage.
We will also need copies of all insurance cards (including Medicare cards).

Patient Name: _____ Age: _____
(Last) (First) (Middle)

Date of Birth: ___/___/____ Gender: ☐ Male ☐ Female Home Phone: (____) _____
mm / dd / yyyy

Address: _____ Cell Phone: (____) _____

City: _____ State: _____ Zip: _____

Patient's Social Security Number: _____-_____-_____ Language Preferred: _____

Employer: _____

Primary Insurance: _____ Medical Group: _____

Secondary Insurance: _____ Medical Group: _____

Third Insurance: _____ Medical Group:_____

Spouse's Name/Guarantor: _____ Guarantor's Date of Birth: _____/_____/_____

Guarantor/Spouse's Social Security Number: _____-_____-_____

Are you living in a skilled nursing facility? ☐ Yes ☐ No

Referring Physician: _____

Primary Medical Doctor: _____

In Case of Emergency— Please list nearest relative/friend we may contact (not living with you).

Name: _____ Telephone: (_____) _____

Insurance Authorization and Assignment

I hereby authorize the Retinal Consultants Medical Group, Inc. to furnish information to insurance carriers, and any other physicians involved in my care, related to my illness and treatments. I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amounts due as a result of providing false or incorrect insurance information and for any non-covered services (as defined by my health plan).

Date: _____ Signature: _____

Revised 10-07-13

Retinal Consultants Medical Group

Electronic Health Record Update/Actualizacion de Historia Clinica Electronica

DEMOGRAPHICS/DEMOGRAFIA:

Name: **Date of birth:**
Nombre: _____ ***Fecha de nacimiento*** _____

Retina Physician: **Chang Equi Patel Pearlman Reed Telander Tsai Wendel**

Office:
Oficina: _____

Race/Raza: (Circle one/Circule uno)

American Indian or Alaska native
Indioamericano o Native de Alaska

Asian
Asiatica

Black or African American
Africano Americano

Native Hawaiian or Pacific Islander
Nativo Hawaiiano o de isla Pacifica

White
Blanco

Other Race
Otra raza

More than one race
Más de una raza

Choose not to answer
Prefiere no contestar

Hispanic or Latino
Hispano o Latino

Language preference/Preferencia de lenguaje: (circle one/*circule uno*)
English/*Inglés* Spanish/*Español* Russian/*Ruso* Other/*Otro*_____

FAMILY HISTORY/HISTORIA FAMILIA:

Does anyone in your **family** (related to you) have:
Alguna persona de su familia tiene:

Blindness/*Ceguera:*	NO	YES/*SI*	If yes, Who?_____ *¿Si contesta sí, quien?* _____
Retinal disease /*lenfermedad retinal:*	NO	YES/*SI*	If yes, Who?_____ *¿Si contesta sí, quien?* _____
Glaucoma:	NO	YES/*SI*	If yes, Who?_____ *¿Si contesta sí, quien?* _____

(CONTINUED ON THE NEXT PAGE / CONTINUA EN LA PAGÍNA PROXIMO)

SOCIAL HISTORY/HISTORIA SOCIAL: (mark the appropriate check box and/ or fill in the blanks/*circule o llene la linea*)

SMOKING ☐ I don't smoke and have never smoked
FUMAR: ☐ *Yo no fumo y nunca e fumado*
☐ I am a former smoker and smoked for _____ years
☐ *Antes fumaba y fume por _____años*
☐ I smoke and smoke _____ packs per day
☐ *Fumo y fumo _____ paquetes por día*

ALCOHOL: ☐ I don't drink any alcohol
☐ *Yo no tomo alcohol*
☐ I occasionally drink alcohol
☐ *Ocasionalmente tomo alcohol*

OCCUPATION/ ☐ Retired/
OCUPACIÓN: _____ *Retiradora*

PAST MEDICAL HISTORY/*HISTORIA ANTERIOR MÉDICA*:

Medical Problems/*Problemas Médicos:*

☐ I have **NO previous medical problems/** ***Yo nunca e tenido ninguno de estos problemas medicos.***

Please indicate if you have **PREVIOUSLY** had any of the following conditions:
Por favor indicar si usted previamente tuvo alguna de las siguientes condiciónes:

☐ Retinal surgery - (please explain on next page) *Cirugía de retina - (por favor, explique en la página siguiente)*	☐ Other eye surgeries (please provide details on next page i.e. cataracts, laser) *Otro cirugía de ojos (por favor describa el tipo de cirugía)*	
☐ Cataracts/ *cataratas*	☐ Epilepsy (seizures) *Epilepsia (convulsiones)*	☐ Strokes *Accidente cerebrovascular*
☐ High blood pressure *Presión arterial alta*	☐ High cholesterol *Cholesterol alto*	☐ Heart murmur *Sopio cardiaco*
☐ Irregular Heart Rhythm *Ritmo cardiac irregular*	☐ Angina/Chest Pain *Dolor de pecho*	☐ Heart problems *Problemas cardiacos*
☐ Asthma/*asma*	☐ Pneumonia/*Neumonia*	☐ Pulmonary embolism *Embolia pulmunar*
☐ Tuberculosis	☐ Emphysema/*enfisema*	☐ Thyroid Issues (list type) *Problemas de tiroides y cual*
☐ Goiter/*Bocio*	☐ Jaundice/*Ictericia*	☐ Anemia
☐ Hepatitis	☐ Stomach or peptic ulcer *Ulcera estomacal o peptica*	☐ Colitis
☐ Rheumatic fever *Fiebre rheumatica*	☐ Kidney disease *Enfermedad renal*	☐ Kidney stones *Calculos renales*
☐ Cancer (type)		

(CONTINUED ON THE NEXT PAGE / CONTINUA EN LA PAGÍNA PROXIMO)

☐ Diabetes: diagnosed in _____ ☐ Require Insulin Most recent A1C: _____
Diabetes: diagnosticado en _____ ☐ *Requierre insulin. Más reciente A1C* _____

Please indicate if you have any of the following problems within the **last month:**
Por favor indicar si usted tuvo alguno de los siguientes problemas dentro de el mes pasado

☐ I have **not experienced any of these symptoms** in the last month.
Yo no e tenido ninguno de estos sintomas en el mes pasado

GENERAL

- ☐ Recent unexplained weight gain;how much____ *Aumento de peso inexplicable; cuanto* _____
- ☐ Recent unexplained weight loss: how much____ *Perdida de peso inexplicable; cuanto* _____
- ☐ Fatigue/*fatiga*
- ☐ Weakness/*Debilidad*
- ☐ Fever/*Fiebre*
- ☐ Night sweats/*Sudar de noche*

MUSCLE/JOINTS/BONES
MUSCULOS/ARTICULACIONES/ HUESOS

- ☐ Numbness/Entumecimiento
- ☐ Joint pain/*Dolor de articulaciones*
- ☐ Muscle weakness *Debilidad muscular*
- ☐ Joint swelling: Where?
- ☐ *Hinchazon de articulaciones, donde:*

KIDNEY/URINE/BLADDER
RIÑÓN/ORINA/VEJIGA

- ☐ Frequent or painful urination *Orinar frequentemente o con dolor*
- ☐ Blood in urine *Sangre en la orina*

NERVOUS SYSTEM/
SISTEMA NERVIOSO

- ☐ Headaches *dolor de cabeza*
- ☐ Dizziness/*Mareo*
- ☐ Fainting or loss of consciousness *Desmayo o perdida de*
- ☐ Numbness or tingling *Entumecimiento o hormigueo*
- ☐ Memory loss *Perdida de memoria*

EARS/OIDOS

- ☐ Ringing in ears *Zumbido en los oidos*
- ☐ Loss of hearing *Perdida de audicion*

PSYCHIATRIC/
PSIQUIÁTRICO

- ☐ Depression/*deprecion*
- ☐ Excessive worries/ *Preocupaciones excesivas*

SKIN/PIEL

- ☐ Redness/*enrojecimiento*
- ☐ Rash/*Ronchas*
- ☐ Nodules/bumps/*nodulos*
- ☐ Hair loss /*Perdida de pelo*

BLOOD/*SANGRE*

- ☐ Anemia
- ☐ Clots/*Coagulos*

HEART AND LUNGS/
CORAZON Y PULMONES

- ☐ Chest pain/*dolor de peso*
- ☐ Palpitations/*palpitaciones*
- ☐ Shortness of breath/*falta de aliento*
- ☐ Fainting/*Desmayo*
- ☐ Swollen legs or feet *piernas o pies hinchados*
- ☐ Cough/*tos*

STOMACH AND INTESTINES/
ESTÓMAGO Y LOS INTESTINOS

- ☐ Nausea
- ☐ Heartburn/*acidos*
- ☐
- ☐ Blood in stools *Sangre in las heces*
- ☐ Black stools *Heces negras*

(CONTINUED ON THE NEXT PAGE / *CONTINUA EN LA PAGÍNA PROXIMO*)

If you have answered YES to any of the questions above and on the previous page, please provide details below. If you need more space, please attach your additional comments to this document.

Si usted contest sí a alguna de las preguntas de arriba y en la pagína anterior, per favor, pong alas detalles abajo si necesita más espacio, por favor adjunte sus comentarios adicionales a este documento.

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES/*ALERGIAS*:

Please list your current **ALLERGIES** to any medications and reactions
Por favor listé sus alergias a cualquier medicamento y reacciones

☐ I have **no known medication allergies**/*No tengo allerias a las medicaciones.*

Allergen/*Alergeno*	**Reaction/*Reacción*** (i.e. rash)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

(CONTINUED ON THE NEXT PAGE / *CONTINUA EN LA PAGÍNA PROXIMO*)

Name/: _____ DOB: _____
Nombre *Fecha de nacimiento*

PATIENT MEDICATION LIST

MEDICATIONS/*MEDICACIONES*:

☐ I am not currently taking any medications/*No estoy usando ningun medicamento.*

☐ I am on a medication regimen. (Please **complete the attached medication list form**). *Estoy en un regimen de medicamentos (por favor completé la forma adjunta de la lista de mdicaciones*

Please list for us any medications you are taking including dietary/nutritional supplements, vitamins, minerals, over the counter, and herbal medications.

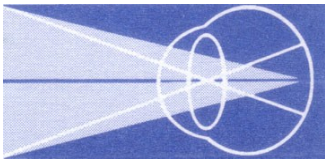
Medication Name ***Nombre de medicacion***	**Dose** ***Dosis***	**Route** (i.e. orally, injection, patch) *Routa*	**Frequency** (i.e. once a day, twice a day, etc.) *Frequencia* *(una día, dos al día)*

RETINAL CONSULTANTS MEDICAL GROUP, INC.

Members of the American Society of Retinal Specialists

Serving Northern California since 1975

http://www.retinalmd.com



INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist 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 is best if you make arrangements not to drive yourself.

Adverse reaction, 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 Dr. Chang / Equi / Patel / Pearlman / Reed / Tsai / Wendel and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____

Patient (or person authorized to sign for patient) Date

_____ _____

Witness Date

Revised 4/22/2014

Acknowledgement of Receipt of Notice

Vitreo-Retinal Medical Group, Inc.

dba Retinal Consultants Medical Group, Inc.

Main Office

3939 J Street, STE 104

Sacramento, CA 95819

Chris Mentink, Privacy Officer - 916-453-5450

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient:

- ❑ parent or guardian of minor patient
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient

Name of Patient: _____

***For Office Use Only*:**

- ❑ Signed form received by: _____
- ❑ Acknowledgment refused:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____