

# 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: (\_\_\_\_) \_\_\_\_\_

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## 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: \_\_\_\_\_

## Retinal Consultants Medical Group

### Electronic Health Record Update/Actualizacion de Historia Clinica Electronica

**DEMOGRAPHICS/DEMOGRAFIA:**

<b>Name:</b> <b>Nombre:</b> _____ Retina <b>Chang Equi Patel</b> <b>Physician:</b> <b>Pearlman Reed</b> <b>Doctor:</b> <b>Telander Tsai Wendel</b>	<b>Date of birth:</b> <b>Fecha de nacimiento</b> _____  <b>Office:</b> <b>Oficina:</b> _____
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**Race/Raza:** (Circle one/Circule uno)

American Indian or Alaska native <i>Indioamericano o Native de Alaska</i>	Asian <i>Asiatica</i>	Black or African American <i>Africano Americano</i>
Native Hawaiian or Pacific Islander <i>Nativo Hawaiano o de isla Pacifica</i>	White <i>Blanco</i>	Other Race <i>Otra raza</i>
More than one race <i>Más de una raza</i>	Choose not to answer <i>Prefiere no contestar</i>	Hispanic or Latino <i>Hispano o Latino</i>

**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:*

<b>Blindness/Ceguera:</b>	NO	YES/SI	If yes, Who? _____ ¿Si contesta sí, quien? _____
<b>Retinal disease /enfermedad retinal:</b>	NO	YES/SI	If yes, Who? _____ ¿Si contesta sí, quien? _____
<b>Glaucoma:</b>	NO	YES/SI	If yes, Who? _____ ¿Si contesta sí, quien? _____

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

**SMOKING****FUMAR:**

- I don't smoke and have never smoked  
 *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/  
OCUPACIÓN:**

- Retired/  
*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 condiciones:*

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

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

- |  |   |
|--|---|
| <input type="checkbox"/> Diabetes: diagnosed in _____<br><i>Diabetes: diagnosticado en _____</i> | <input type="checkbox"/> Require Insulin Most recent A1C: _____<br><i>Requierre insulin. Más reciente A1C _____</i> |
|--|---|

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

<p style="text-align: center;"><b>GENERAL</b></p> <p><input type="checkbox"/> Recent unexplained weight gain;how much _____  <i>Aumento de peso inexplicable; cuanto _____</i></p> <p><input type="checkbox"/> Recent unexplained weight loss: how much _____  <i>Perdida de peso inexplicable; cuanto _____</i></p> <p><input type="checkbox"/> Fatigue/<i>fatiga</i></p> <p><input type="checkbox"/> Weakness/<i>Debilidad</i></p> <p><input type="checkbox"/> Fever/<i>Fiebre</i></p> <p><input type="checkbox"/> Night sweats/<i>Sudar de noche</i></p> <p style="text-align: center;"><b>MUSCLE/JOINTS/BONES</b>  <b>MUSCULOS/ARTICULACIONES/HUESOS</b></p> <p><input type="checkbox"/> Numbness/<i>Entumecimiento</i></p> <p><input type="checkbox"/> Joint pain/<i>Dolor de articulaciones</i></p> <p><input type="checkbox"/> Muscle weakness  <i>Debilidad muscular</i></p> <p><input type="checkbox"/> Joint swelling: Where?</p> <p><input type="checkbox"/> <i>Hinchazon de articulaciones, donde:</i></p> <p style="text-align: center;"><b>KIDNEY/URINE/BLADDER</b>  <b>RIÑÓN/ORINA/VEJIGA</b></p> <p><input type="checkbox"/> Frequent or painful urination  <i>Orinar frecuentemente o con dolor</i></p> <p><input type="checkbox"/> Blood in urine  <i>Sangre en la orina</i></p>	<p style="text-align: center;"><b>NERVOUS SYSTEM/ SISTEMA NERVIOSO</b></p> <p><input type="checkbox"/> Headaches  <i>dolor de cabeza</i></p> <p><input type="checkbox"/> Dizziness/<i>Mareo</i></p> <p><input type="checkbox"/> Fainting or loss of consciousness  <i>Desmayo o perdida de</i></p> <p><input type="checkbox"/> Numbness or tingling  <i>Entumecimiento o hormigueo</i></p> <p><input type="checkbox"/> Memory loss  <i>Perdida de memoria</i></p> <p style="text-align: center;"><b>EARS/OIDOS</b></p> <p><input type="checkbox"/> Ringing in ears  <i>Zumbido en los oidos</i></p> <p><input type="checkbox"/> Loss of hearing  <i>Perdida de audicion</i></p> <p style="text-align: center;"><b>STOMACH AND INTESTINES/ ESTÓMAGO Y LOS INTESTINOS</b></p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Heartburn/<i>acidos</i></p> <p><input type="checkbox"/></p>	<p style="text-align: center;"><b>PSYCHIATRIC/ PSIQUIÁTRICO</b></p> <p><input type="checkbox"/> Depression/<i>deprecion</i></p> <p><input type="checkbox"/> Excessive worries/  <i>Preocupaciones excesivas</i></p> <p style="text-align: center;"><b>SKIN/PIEL</b></p> <p><input type="checkbox"/> Redness/<i>enrojecimiento</i></p> <p><input type="checkbox"/> Rash/<i>Ronchas</i></p> <p><input type="checkbox"/> Nodules/bumps/<i>nodulos</i></p> <p><input type="checkbox"/> Hair loss /<i>Perdida de pelo</i></p> <p style="text-align: center;"><b>BLOOD/SANGRE</b></p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Clots/<i>Coagulos</i></p> <p style="text-align: center;"><b>HEART AND LUNGS/ CORAZON Y PULMONES</b></p> <p><input type="checkbox"/> Chest pain/<i>dolor de peso</i></p> <p><input type="checkbox"/> Palpitations/<i>palpitaciones</i></p> <p><input type="checkbox"/> Shortness of breath/<i>falta de aliento</i></p> <p><input type="checkbox"/> Fainting/<i>Desmayo</i></p> <p><input type="checkbox"/> Swollen legs or feet  <i>piernas o pies hinchados</i></p> <p><input type="checkbox"/> Cough/<i>tos</i></p> <p><input type="checkbox"/> Blood in stools  <i>Sangre in las heces</i></p> <p><input type="checkbox"/> Black stools <i>Heces negras</i></p>
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(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 contestó sí a alguna de las preguntas de arriba y en la página anterior, por favor, ponga los detalles abajo si necesita más espacio, por favor adjunte sus comentarios adicionales a este documento.*

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**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 alergias a las medicaciones.*

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

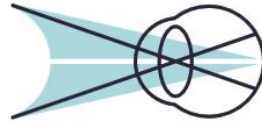


# RETINAL CONSULTANTS MEDICAL GROUP

Members of the American Society of Retinal Specialists

Established in 1977

[www.retinalmd.com](http://www.retinalmd.com)



Retinal  
Consultants  
MEDICAL GROUP

## 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 the doctors at Retinal Consultants Medical Group 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

## 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: \_\_\_\_\_

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### ***For Office Use Only:***

Signed form received by: \_\_\_\_\_

Acknowledgment refused:

Efforts to obtain:

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

Reasons for refusal:

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