RETINA ASSOCIATES of Southern Utah
LEADER IN ADVANCED RETINAL TREATMENT & SURGERY

# Patient Data Sheet

Medical Record No. _____

| PATIENT INFORMATION | | | |
|---|---|---|---|
| Name (Last, First, Middle Initial) | | Date of Birth | Sex ☐ Male ☐ Female |
| Home Address | | Patient SSN | |
| City, State, Zip | | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated | |
| Home Phone | Cell phone | Employer Name and Phone | |
| Email Address | | Referring Physician | |
| Primary Care Physician | | Emergency Contact Name and Phone number | |
| Race ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Asian ☐ White/Caucasian ☐ Native Hawaiian or Pacific Islander ☐ Other | | | |
| Ethnicity ☐ Non-Hispanic or Latino ☐ Hispanic or Latino | | Preferred Language | |

| RESPONSIBLE PARTY INFORMATION (if different than above) | | |
|---|---|---|
| Name (Last, First, Middle Initial) | Responsible Party SSN | Sex ☐ Male ☐ Female |
| Home Address | Relationship to Patient | Date of Birth |
| City, State, Zip | Home Phone | Cell Phone |

| PRIMARY INSURANCE INFORMATION | | |
|---|---|---|
| Name of Insurance Company | Policy # or ID # | |
| Subscriber Name | Insured Social Security # | Insured date of birth |
| Relationship to Patient | | |

| SECONDARY INSURANCE INFORMATION | | |
|---|---|---|
| Name of Insurance Company | Policy # or ID # | |
| Subscriber Name | Insured Social Security # | Insured date of birth |
| Relationship to Patient | | |

Patient Occupation: _____

Pharmacy name, address & phone: _____

**Is this a work related injury?** ☐ **Yes** ☐ **No**

_____ _____

**SIGNATURE OF PATIENT/GUARDIAN** **DATE**

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## PATIENT MEDICAL HISTORY FORM

| Do you now, or have you ever had: | Yes/No | Current Treatment/ Previous Surgery | When? |
|---|---|---|---|
| **Diabetes** Type 1 or Type 2 | ☐ **Yes** ☐ **No** | | |
| **Heart Disease** | ☐ **Yes** ☐ **No** | | |
| **Pacemaker / Defibrillator** | ☐ **Yes** ☐ **No** | | |
| **High Blood Pressure** | ☐ **Yes** ☐ **No** | | |
| **High Cholesterol** | ☐ **Yes** ☐ **No** | | |
| **Kidney Disease** | ☐ **Yes** ☐ **No** | | |
| **Dialysis** | ☐ **Yes** ☐ **No** | | |
| **Liver Disease** | ☐ **Yes** ☐ **No** | | |
| **Stroke** | ☐ **Yes** ☐ **No** | | |
| **Anemia** | ☐ **Yes** ☐ **No** | | |
| **Asthma or Lung Disease** | ☐ **Yes** ☐ **No** | | |
| **Thyroid Disease** | ☐ **Yes** ☐ **No** | | |
| **Cancer or Tumor Type:** | ☐ **Yes** ☐ **No** | | |
| **Arthritis Type:** | ☐ **Yes** ☐ **No** | | |
| **Other medical Problems or Surgeries:** | ☐ **Yes** ☐ **No** | | |

**Family History:** **Relationship:**

| | | | |
|---|---|---|---|
| ☐ Yes | ☐ No | High blood pressure | _____ |
| ☐ Yes | ☐ No | Diabetes | _____ |
| ☐ Yes | ☐ No | Cancer | _____ |
| ☐ Yes | ☐ No | Glaucoma | _____ |
| ☐ Yes | ☐ No | Cataracts | _____ |
| ☐ Yes | ☐ No | Retinal Disease | _____ |
| ☐ Yes | ☐ No | Macular degeneration | _____ |
| ☐ Yes | ☐ No | Keratoconus | _____ |
| ☐ Yes | ☐ No | Other eye/Medical Problems | _____ |
| ☐ Yes | ☐ No | | _____ |
| ☐ Yes | ☐ No | | _____ |

**Social History:**

**Tobacco:** ☐ Never ☐ Current ☐ Former
Year Quit: _____
Number Per Day:_____ How Long: _____

**Alcohol:** ☐ No ☐ Yes Amount: _____

**Street Drugs:** ☐ No ☐ Yes (Type) _____

**Caffeine:** ☐ No ☐ Yes Amount: _____

**Please list prescribed and over-the-counter medications, including vitamins and supplements you are currently taking:**

| Name of Medication | Reason for Taking | Name of Medication | Reason for Taking |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| Allergies to Medications | Reaction / Severity | Allergies to Medications | Reaction / Severity |
|---|---|---|---|
| | | | |
| | | | |

**Have you ever taken or are you taking any of these medications?**

☐ Cortizone or Steroid ☐ Plaquenil ☐ Tamoxifen ☐ Phenothiazine ☐ Flomax ☐ None of these

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## OCULAR HISTORY

| Do you currently have, or have you ever had: | Yes/No | Diagnosis | Current Treatment/ Previous Surgery | When? |
|---|---|---|---|---|
| Eye Disease | ☐ Yes ☐ No | | | |
| Eye injury | ☐ Yes ☐ No | | | |
| Eye surgery | ☐ Yes ☐ No | | | |
| | | | | |

## REVIEW OF SYSTEMS - Do you *currently* have any problems in the following areas?

| System | Yes/No | System | Yes/No |
|---|---|---|---|
| **Constitutional**: Fever | ☐ Yes ☐ No | **Neurological:** Dizziness | ☐ Yes ☐ No |
| Weight: ☐ Loss ☐ Gain | ☐ Yes ☐ No | Headache | ☐ Yes ☐ No |
| **Cardiovascular**: Chest Pressure or Discomfort | ☐ Yes ☐ No | Numbness of Extremities | ☐ Yes ☐ No |
| Irregular Heartbeat/Palpitations | ☐ Yes ☐ No | **Musculoskeletal**: Muscle Weakness | ☐ Yes ☐ No |
| **Metabolic**: Intolerant to: ☐ Cold ☐ Heat | ☐ Yes ☐ No | Joint Swelling/Arthritis | ☐ Yes ☐ No |
| **Endocrine**: Excessive thirst (polydipsia) | ☐ Yes ☐ No | **Respiratory**: Difficulty Breathing (dyspnea) | ☐ Yes ☐ No |
| Urinating more than usual (polyuria) | ☐ Yes ☐ No | Cough | ☐ Yes ☐ No |
| **Integumentary/Skin**: Dry Skin | ☐ Yes ☐ No | **Genitourinary**: Painful Urination (dysuria) | ☐ Yes ☐ No |
| Rash/Lesions | ☐ Yes ☐ No | **Psychiatric:** Depressed Mood / Anxiety | ☐ Yes ☐ No |
| **Ear/Nose/Throat**: Hearing Loss | ☐ Yes ☐ No | **Hematologic/Lymphatic:** | ☐ Yes ☐ No |
| Sinus Problems | ☐ Yes ☐ No | Easily ☐ Bleeds and/or ☐ Bruises | ☐ Yes ☐ No |
| Sore Throat | ☐ Yes ☐ No | Swollen lymph nodes (lymphadenopathy) | ☐ Yes ☐ No |
| **Gastrointestinal**: Abdominal Pain | ☐ Yes ☐ No | **Allergic/Immunologic:** | ☐ Yes ☐ No |
| Heartburn | ☐ Yes ☐ No | ☐ Food Allergies ☐ Seasonal Allergies | ☐ Yes ☐ No |
| Vomiting | ☐ Yes ☐ No | **Do you need assistance walking?** | ☐ Yes ☐ No |
| | | **FEMALES: are you pregnant or breast feeding?** | ☐ Yes ☐ No |

What brought you to our clinic today? Please describe any symptoms and when they began:

_____

_____

_____

## LIFETIME AUTHORIZATION

The following is a lifetime authorization permitting RASU to provide information to your insurance company, Medicare, medical providers and others who are legally entitled:

I authorize reports of my evaluation, treatments and any follow up evaluations to be sent to my referring physician, optometrist, consulting physician, my primary care physician and any health care providers that I have or will identify to RASU. I also authorize release of all pertinent medical information to any hospital, outpatient facility or clinic. Photography may be used in the evaluation and management of my condition. I consent to the taking of such photographs, if necessary, and to their possible use in medical meetings, books, journals or other aspects of medical education. I understand that if my photographs/images are used, my name will not be used.

**If provided, I authorize the use of email as a means of contact: email address:** _____

I UNDERSTAND THAT I AM FULLY AND LEGALLY RESPONSIBLE FOR PAYMENT OF THE ACCOUNT WHICH INCLUDES ALL OUTSTANDING BALANCES NOT COVERED BY MEDICARE AND/OR INSURANCE COMPANIES.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agents of my insurance companies indicated, or to my employer if this is a workers compensation claim, any information, including retirement dates, needed for this or a related insurance or Medicare claim. I permit a copy of this authorization to be used in place of the original. I request payment of medical insurance benefits to me or to a party who accepts assignment.

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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## FINANCIAL POLICY

Thank you for selecting Retina Associates of Southern Utah (RASU) for your retinal care. We are committed to providing the best eye care possible. The following information outlines financial responsibilities related to payment for your professional services.

You, the patient, are ultimately responsible for all charges associated with your care. RASU participates with a variety of insurance plans. We refer to "in network" as the insurance companies that we have a contract agreement with. Please be aware, you incur more out of pocket expenses for seeing a doctor out of network. It is your responsibility to check your insurance company for coverage and participation detail.

We will submit insurance claims on your behalf to your primary insurance and one to secondary insurance carrier. However, it is important to remember that your insurance is a contract between you and your insurer and it is your responsibility to know and understand the requirements of your insurance plan. We will not be responsible if you do not follow the specific terms of your insurance agreement and if we do not receive payment from them, you will be responsible.

It is your responsibility to:

1. Bring your insurance card and picture ID to every visit.
2. Be prepared to pay for your co-pay and non-covered services at each visit.
3. Obtain any referrals that your insurance requires.
4. Provide a valid physical address. Post office boxes may be used as mailing addresses only.

Failure to provide any of the above may require you to pay in full or reschedule your visit.

If there is a remaining balance due after your insurance carrier pays, you will be billed. If that balance is not paid within 60 days, we send outstanding balances to an outside collection agency without further notice. Payment arrangements can be made, but it is your responsibility to contact the billing office before it is turned over to an outside agency. The billing office can be reached at (435) 216-7032.

We accept cash, check, Visa, MasterCard, Discover, and American Express.

If the patient is a minor (17 years and younger), the parent or guardian must also sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at the time of service, required referrals, insurance and picture ID cards.

Our office will do what we can to assist you. If you have any questions or concerns, please do not hesitate to contact our billing office at (435) 216-7032, Monday through Friday, 8:00 am to 5:00 pm. Retina Associates of Southern Utah believes that a good physician/patient relationship is based on understanding and communication. Your signature below indicates that you have read and agree to this Financial Policy.

_____ _____

*Patient/Guardian Signature* *Date*

_____ _____

*Witness* *Date*

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## PERSONAL REPRESENTATIVE DESIGNATION

This section allows you to give Retina Associates of Southern Utah permission to discuss your Protected Health Information with a person(s) you appoint as your Personal Representative. You are not required to name a personal representative, but if you do not, we will not disclose your Protected Health Information to someone who may call on your behalf. Your Personal Representative may be anyone of your choosing such as a spouse, parent, child, or friend. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records accordingly, and speak to your personal representative.

You may revoke this designation of a Personal Representative at any time by giving written notice to the Privacy Official.

☐ **I decline to name a Personal Representative.** **OR Designate Representative(s) below**

**1. Personal Representative**

Full Name: _____ Relationship: _____

Contact Phone: _____ Date of Birth: _____

Any limitations on issues your personal representative may discuss: (please circle) YES NO

If yes, please specify (i.e. medical, financial, etc.): _____

**2. Personal Representative**

Full Name: _____ Relationship: _____

Contact Phone: _____ Date of Birth: _____

Any limitations on issues your personal representative may discuss: (please circle) YES NO

If yes, please specify (i.e. medical, financial, etc.): _____

**3. Personal Representative**

Full Name: _____ Relationship: _____

Contact Phone: _____ Date of Birth: _____

Any limitations on issues your personal representative may discuss: (please circle) YES NO

If yes, please specify (i.e. medical, financial, etc.): _____

## NOTICE OF PRIVACY PRACTICES

**ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have received a copy of Retina Associates of Southern Utah's Notice of Privacy Practices effective November 1, 2014.**

**Name (please print): _____ Date: _____**

**Signature: _____ Relationship to Patient:** ☐ **Self** ☐ **Parent** ☐ **Legal Guardian**

RASU Witness Signature _____ Date _____