THE WOODLANDS RETINA CENTER
VITREO-RETINAL DISEASES AND SURGERY

1001 Medical Plaza Dr.
The Woodlands, TX 77380
www.woodlandsretina.com
Tel: 281-367-9700 Fax: 281-367-9701

PATIENT INFORMATION

Patient's *Legal* Name: _____

Date of Today's Visit:_____Social Security # _____

Date of Birth:_____Age:_____Sex: M F Marital Status: S M D W

Address: (Street) _____

(City, State, Zip) _____

Phone #_____Cell #_____Work # _____

Name of Spouse:_____Emergency Contact Name and Number: _____

Name of Referring Physician_____Phone # of Referring Physician_____

Date of Last Exam with Referring Physician:_____

Name of Primary Care Physician: _____Phone # of Primary Care Physician:_____

Occupation:_____Is this a work related injury?_____

Employer: _____

Employer Address: _____

PRIMARY INSURANCE INFORMATION

Insurance Co.:_____ ID #_____Group # _____

Insured's Name:_____ Relationship to Patient____Self_____Spouse____Dependent

Insured's Employer:_____Phone #: _____

Employer's Address:_____

Insured's Social Security #_____ Date of Birth: _____

Sex____M____F

I hereby assign, transfer, and set over The Woodlands Retina Center all my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of my medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature:_____Date: _____

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MEDICAL FORM

Patient Name:_____Referring Doctor: _____

DOB:_____Age:_____Primary Doctor: _____

Eye History

1. What specific eye problems or visual difficulties are you experiencing now?

_____

_____

2. Do you or a blood relative have any of the following eye diseases:

	You		**Family Member** (specify relation)	
Glaucoma	Yes	No	Yes	No
Cataracts	Yes	No	Yes	No
"Lazy eye" or muscle imbalance	Yes	No	Yes	No
Retinal disease	Yes	No	Yes	No
Macular degeneration	Yes	No	Yes	No
Other eye problem	Yes	No (if yes, specify)	Yes	No (if yes, specify)

3. Have you had any eye surgery, laser treatments to the eye, or eye injury? Yes No

If yes, please explain:

4. What *eye* medications are you using at present? Give name(s) and dosages and how often you take them:

5. Do you wear glasses? Yes No

6. Do you wear contacts? Yes No If yes, what brand and power: _____

7. When was your last eye exam? Who was your previous eye doctor? _____

Medical History

8. Do you have now, or have you had any of the following: If yes, please explain:

Diabetes mellitus	Yes No	If yes, explain duration & treatment.
Heart attack	Yes No	
Angina or chest pain	Yes No	
Irregular or rapid heart beat	Yes No	
Heart failure	Yes No	
Cardiac pacemaker inserted	Yes No	
High blood pressure	Yes No	
High cholesterol A stroke or "shock"	Yes No	
Anemia	Yes No	
Emphysema or bronchitis	Yes No	
Asthma	Yes No	If yes, list type.
Stomach or duodenal ulcer	Yes No	
Arthritis	Yes No	
Thyroid Disease	Yes No	If yes, list type, location, date and treatment given.
Cancer or tumor	Yes No	
Seizures	Yes No	
Migraine headaches	Yes No	
For females, are you pregnant or nursing?	Yes No	
Other medical problems	Yes No	

9. What medication or vitamins do you take? Give name(s) and dosage:

10. What operations (other than eye surgery) have you had?

11. Do you smoke? Yes No

12. Occupation:_____ Hobbies: _____

Family History

13. Among blood relatives, is there a history of any of the following:

Diabetes	Yes No	
Tumor or cancer	Yes No	
High blood pressure	Yes No	
Heart disease	Yes No	
Other medical problems	Yes No	Please specify:

Review of Systems

Please circle any of the following symptoms that you are currently experiencing:

General	Fever, weight loss, weight gain
Eye	Blurred vision, fluctuating vision, loss of side vision, double vision, dryness, excess tearing, mattering, redness, itching, burning, glare, light sensitivity, eye pain
Ear, Nose, Throat	Sinus congestion, runny nose, postnasal drip, dry mouth
Heart	Chest pains, palpitations
Lungs	Shortness of breath, cough
Gastrointestinal	Reflux, nausea, vomiting
Hematologic / Lymphatic	Kidney stones, bladder problems, dialysis
Musculoskeletal	Joint pain, arthritis, muscle weakness, back pain
Skin	Rashes
Neurologic	Dizziness, headache, memory loss
Psychiatric	Anxiety, depression
Allergic / Immunologic	Sneezing, itching

14. Please give the name(s) and relationship of individuals that your medical condition can be discussed with:

_____

_____

Completed by:_____ Physician signature: _____ Date:_____

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NOTICE OF PRIVACY PRACTICES

I have reviewed the The Woodlands Retina Center's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

_____ _____

Signature Date

Patient's name - Printed

THE FOLLOWING SECTION IS TO BE COMPLETED IF APPLICABLE:

On behalf of the patient listed below, I have received a copy of The Woodlands Retina Center's Notice of Privacy Practices, which explains how the patient's medical information will be used and disclosed.

I am authorized to sign on the patient's behalf in the capacity of (check one):

_____ Legal Guardian (documentation required)
_____ Power of Attorney (documentation required)
_____ Parent of a Minor

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize The Woodlands Retina Center to disclose my protected health information to the following of my family and friends:

NAME _____ NAME _____

_____ _____

I authorize the disclosure of the protected health information as indicated below:

Release	Do Not Release	Information	Release	Do Not Release	Information
		History / Consult			Treatment Plan Operative
		Diagnosis			Reports
		Findings on Exam			Clinic / Progress Notes
		Diagnosis Studies			Laboratory Reports
		Return to Work / Status / Restrictions			Other (specify):

Purpose of disclosure:_____Insurance:_____

I understand that The Woodlands Retina Center will not place any conditions on my treatment, payment, enrollment in a health plan, or eligibility for benefits based on whether or not I provide authorization or the purpose of disclosure for any of the above information.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

This authorization shall be effective until the following date: (if not indicated otherwise, authorization will be effective for 12 months from the date signed.)

I understand that I have the right to revoke this authorization at any time by sending written notification to the Woodlands Retina Center at

The Woodlands Retina Center
1001 Medical Plaza Drive, Ste 240
The Woodlands, TX 77380

I understand that a revocation does not affect any information released according to the terms of this authorization prior to the receipt of the written notification of revocation. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I agree that disclosure of the information indicated may be transmitted by fax _____Yes_____No
I agree that a photocopy of this authorization may be considered valid _____Yes_____No

Patient/Guardian (Signature)_____Date: _____
Patient Name (Printed)_____Date of Birth: _____
Witness (Signature) _____

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PATIENT INFORMATION AND CONSENT FOR DILATED OCULAR EXAMINATION

Dear Patient:

In order for the physician to perform a thorough evaluation of the retina and vitreous of your eyes, it will be necessary that your eyes be dilated prior to this examination and all future examinations in our office. This is a simple procedure, consisting of instilling dilating drops in both eyes.

The effects of the dilation usually take four to six hours to wear off. During that time, you may have difficulty with focusing for near visual activities. You may also experience problems with driving, due to increased sensitivity to light, during this period.

RE:_____(PATIENT)

I have been informed of the potential risks and problems which I may experience as a result of having my eyes dilated. I consent to dilation of my eyes for this examination, as well as any future examinations by a physician with The Woodlands Retina Center.

Signature, Patient or Legal Guardian/Representative

_____

Name Printed, Patient or Legal Guardian/Representative

_____

Signature / Name Printed / Witness

_____

Date