

Name:

Date:

ALAN L. WAGNER, M.D. F.A.C.S.
KAPIL KAPOOR, M.D.

DISEASES & SURGERY OF RETINA & VITREOUS
MACULAR DEGENERATION
DIABETIC RETINOPATHY
RETINAL DETACHMENT
ADULT & PEDIATRIC RETINAL SURGERY
OCULAR ONCOLOGY / BRACHYTHERAPY
INDOCYANINE GREEN ANGIOGRAPHY
“CLINICAL RESEARCH TRIALS”

Dear Patient,

Our records indicate you have an upcoming scheduled appointment at the Wagner Macula & Retina Center with Alan L. Wagner, M.D., F.A.C.S. or Kapil Kapoor, M.D., who specializes in diseases of the retina and macula.

During your time with us we will work as a team to provide the best care for your eyes. To aid in your care, please complete the enclosed forms, items or information listed below and bring to your first visit:

- Completed medical questionnaire. (Enclosed)
- Completed Notice of Privacy Practices (Enclosed). This form will allow us to discuss your care only with the authorized names you list, in accordance with Health Insurance Portability and Accountability Act (HIPAA). This form is also an acknowledgment that you have the opportunity to receive the Wagner Macula & Retina Center’s Notice of Privacy Practices (NPP).
- Completed “Information Regarding Dilating Eye Drops”. (Enclosed)
- Drivers License or identification card and **INSURANCE CARDS.**
- List of your medications
- Referral - if your insurance requires one.
- Eyeglasses/Sunglasses.

Name:

Date:

On the day of your first visit, a technician will prepare you to see Dr. Wagner or Dr. Kapoor. During this process your eyes will be dilated. The dilating drops blur your vision and make your eyes sensitive to light for several hours. We encourage patients to bring someone to drive them home.

Due to the dilation time and the nature of the examination, your visit may last approximately 2 hours. Please plan accordingly. If you are a diabetic, bring any necessary snacks. If you take medications on a routine time schedule, bring them with you. Due to the type of specialty, our practice encounters emergencies during the day and this may delay the time you are seen by the doctor.

We will gladly file your insurance; however, be prepared to pay your copayment at the time of your visit. Payment arrangements can be made or we do offer a 30% discount to patients that pay in full on that date of service. **(757)-961-2004.**

Due to limited seating, we respectfully request that you be accompanied by only one additional family member, friend or assistant. Should you have any further questions or concerns, please feel free to contact our staff at (757)-481-4400.

****Two business days prior to your scheduled appointment you will receive an automated call reminding you of your appointment date, time and location.****

Sincerely,

Alan L. Wagner, M.D., F.A.C.S.
Kapil G. Kapoor, M.D.
Staff

Wagner Macular & Retina
(757) 481-4400

PATIENT REGISTRATION
(PLEASE PRINT)

Thank you for choosing Wagner Macular & Retina. Please provide us with the information requested below. Please let us know if you need assistance completing this form. If you are a New Patient to Wagner Macular & Retina or an established patient who has not been seen yet this calendar year, please print, verify and fill in any missing information and bring to your next appointment

Last Name: _____ First Name: _____ MI: _____ Suffix: _____

Sex: M F Birthdate: _____ Social Security #: _____

Home Address: _____

City/State/Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____ Marital Status: Single Married Divorced Widow(er)

The following questions are required by the Federal Government HIPAA regulations:

- Race: American Indian or Alaskan Native Asian Black or African American
 Hispanic Native Hawaiian or Pacific Islander White Unknown

Emergency Contact Person (Relative or Friend not living at same address):

Name: _____

Relation to the Patient: _____ Phone #: _____

Pharmacy Information:

Name & Address: _____

Phone #: _____

Referring Physician: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

FINANCIAL POLICY STATEMENT

Wagner Macular & Retina is committed to providing you with the highest quality services available. Please read and sign the following policy. If we are contracted with your insurance, we will accept assignment. All co-pays, co-insurance and deductibles are due and payable at time of service. Failure to provide necessary referrals or current accurate billing information will result in all charges for services to be the sole responsibility of the patient/responsible party. You are expected to understand your benefits coverage and financial responsibility. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payment at time of service. You will be responsible for any balances not covered by your insurance. Should your account be sent to a third party collector, you agree to pay any collection and attorney fees. A return check fee will be assessed if your check is returned by your bank.

Patient's Signature _____ Date _____

(Patient or Legal Representative)

Name: _____

Date: _____

Do you have or have had any of the following medical problems? Circle Yes or No

Diabetes	Yes / No	Year Diagnosed _____
High Blood Pressure	Yes / No	Year Diagnosed _____
Heart Condition	Yes / No	Year Diagnosed _____
Stroke	Yes / No	Year Diagnosed _____
Cancer	Yes / No	Year Diagnosed _____
Lung Disease/ Asthma	Yes / No	Year Diagnosed _____
Skin Disease	Yes / No	Year Diagnosed _____
Bladder/ Prostate	Yes / No	Year Diagnosed _____
HENT (head, ear, nose, throat)	Yes / No	Year Diagnosed _____
Tuberculosis	Yes / No	Year Diagnosed _____
Thyroid	Yes / No	Year Diagnosed _____
Gastrointestinal	Yes / No	Year Diagnosed _____
Neurological	Yes / No	Year Diagnosed _____
Hematologic/ sickle cell/ anemia/ HIV	Yes / No	Year Diagnosed _____
Lymphatic/ Lupus	Yes / No	Year Diagnosed _____
Muscle Skeletal/ Arthritis	Yes / No	Year Diagnosed _____

Do any members of your family (Mother/ Father/ Siblings etc.) have any of the medical conditions listed above? If so, please specify relationship and condition.

Have you ever been diagnosed with any eye diseases? If so, list diagnosis and year diagnosed.

Does any family member have history of eye diseases? If so, please list relationship and disease.

Have you had any previous eye operations? If so, please list type of operation and the year(s).

Have you had any previous operations? If so, please list type of operation and year(s).

Do you smoke? Yes / No
 If so, how much?

Do you drink? Yes / No
 If so, how much?

Do you exercise? Yes/ No
 If so, how much?

Do you use illicit substances/ recreational drugs? Yes / No
 If so, what and how much? _____

OFFICE USE ONLY Above History Reviewed by: _____

Name: _____

Date: _____

Patient Please Complete:

<u>List of Medications</u>	<u>Dosage</u>	<u>Reason for Medication</u>	<u>Technician Initials/Date</u>

<u>Eye Drops or Ointments</u>	<u>Dosage</u>	<u>Reason for Medication</u>	<u>Technician Initials/Date</u>

Medication Allergies: _____

Food Allergies: _____

Name: _____

Date: _____

Notice of Privacy Practices Wagner Macula & Retina Center

The Wagner Macula & Retina Center (WMRC) recognizes that patient information is sensitive and, as such, must be treated carefully and responsibly. A federal regulation, know as HIPAA (Health Insurance Portability and Accountability Act) requires that we provide a detailed notice in writing of our privacy practices. It is the legal duty of WMRC to protect your health information from unauthorized use or disclosure while providing health care, obtaining payment for that health care and for other services relating to your health care.

The purpose of this **Notice of Privacy Practices** is to inform you about how your health information may be used by WMRC, as well as reasons why your health information could be sent to other providers outside of our practice.

The **Notice of Privacy Practices** describes your rights in regards to protection of your health information and how you may exercise those rights. It also gives you the names of contacts should you have questions or comments about the policies and procedures.

There is a copy of the WMRC **Notice of Privacy Practices** available in the lobby for the patient or the patient's representative to review. You may also request a copy from the Practice.

I _____ (*print your name*) hereby authorize the discussion of my medical information and diagnosis including results regarding my care with the Wagner Macula & Retina Center with the following people.

Name _____
Relationship _____ phone number _____

Name _____
Relationship _____ phone number _____

Name _____
Relationship _____ phone number _____

Patient Acknowledgement

I have received and/or had the opportunity to receive the Wagner Macula & Retina Center's Notice of Privacy Practices, which describes the methods for protecting my health information that is used in providing health care services to me.

_____/_____
Patient (or Personal Representative) Date

_____/_____
Witness Date

Note: WMRC retains this signed page

Name: _____

Date: _____

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's 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. _____ and/or such assistants as may be designated by them 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