WAGNER
MACULA & RETINA CENTER
Saving Sight–Enhancing Lives

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.

WAGNER
MACULA & RETINA CENTER
Saving Sight–Enhancing Lives

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
MACULA & RETINA CENTER
Saving Sight–Enhancing Lives

Name:

Date:

Referral Date: _____
Contact Person _____

For Office Use Only:
First Appt Date_____ Time _____
Physician: ALW KGK VB ORF CPK HRC SSE SEP ECG KMK 9VG

PATIENT INFORMATION

Last Name	**First Name**	**MI**

Street Address	**City**	**State**	**Zip**

( ) Single ( ) Married ( ) Widowed ( ) Divorced ( ) Separated

Race (Please Circle One)

American Indian or Alaskan Native Asian Black or African American

Hispanic Native Hawaiian or Pacific Islander White Unknown

Soc Sec No	**Date of Birth**	**Age**	**Sex**

Email Address

Spouse Information

Spouse Name	**Employer**

Spouse SSN #	**Address:**	**Phone Number:**

EMERGENCY CONTACT

Name:	**Relationship:**	**Phone Number:**

Referring Physician:	**Medical Doctor:**
Phone Number:	**Address & Phone Number:**

INSURANCE INFORMATION

Primary Insurance	**Group Number**	**ID Number**

Secondary Insurance	**Group Number**	**ID Number**

I hereby authorize the release of medical information to my insurance company and agree that insurance benefits are to be paid directly to the physician. I understand that any insurance is a contract between me and the insurance company and that any filing on my behalf by the practice is done as a courtesy. I request that payment under Medicare Insurance Program be made on my behalf to the Retina and Vitreous Center, PC for any services furnished by that physician. I am financially responsible for all services. I agree to pay for all costs of collection, including an attorney's fee of 33 1/3% of the balance referred to the attorney in the event of default. (VB ORF CPK HRC SSE SEP ECG KMK 9VG)

Patient or Responsible Party_____ **Date**_____

FOR OFFICE USE ONLY
APPLY ALLERGY LABEL HERE

WAGNER
MACULA & RETINA CENTER
Saving Sight–Enhancing Lives

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:

WAGNER
MACULA & RETINA CENTER
Saving Sight–Enhancing Lives

Name:

Date:

Patient Please Complete:

List of Medications	Dosage	Reason for Medication	Technician Initials/Date

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

Medication Allergies: _____

Food Allergies: _____

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

WAGNER
MACULA & RETINA CENTER
Saving Sight–Enhancing Lives

Name:

Date:

(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

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 of Birth:

WAGNER
MACULA & RETINA CENTER
Saving Sight–Enhancing Lives

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