RETINA GROUP OF FLORIDA

PLEASE FILL OUT ALL PAGES

Patient Name:_____ **Date of Birth:**_____ **Date:** _____
Nombre del Paciente *Fecha de Nacimiento* *Fecha*

Family/Primary Doctor/Internist:_____ **Eye Doctor:** _____
Doctor Familia/Primario/Internista *Doctor de Ojos*

List ALL medical problems:
Enumere TODOS sus problemas médicos

_____

_____

_____

List ALL prescribed medications with dosage:
Enumere TODAS sus medicinas de prescripción incluyendo dosis

_____

_____

_____

_____

Have you received a Pneumonia Vaccination? ☐**YES** ☐**NO** **If YES, date of vaccination:** _____
¿Ha recibido la vacuna contra Neumonía? *SI* *NO* *fecha de vacunación*

Have you received a Flu Vaccination? ☐**YES** ☐**NO** **If YES, date of vaccination:** _____
¿Ha recibido la vacuna contra la Gripe? *SI* *NO* *fecha de vacunación*

LIST ALL EYE DROPS
Enumere TODAS sus gotas para los Ojos

_____

_____

_____

Do you have any ALLERGIES to medications or eye drops? ☐**YES** ☐**NO**
¿Tiene alguna ALERGIA a medicinas o gotas para los ojos? *SI* *NO*

If YES, list the medications and/or eye drops:
Si tiene alergias, enumere las medicinas y/o gotas

_____

_____

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PAST EYE HISTORY
Historia ocular

MARK ALL THAT APPLY
Marque las respuestas que correspondan

☐**CATARACT**
Cataratas

☐**DISTORTION**
Distorsión visual

☐**EYE INJURY/TRAUMA**
Trauma/Herida en los ojos

☐**FLASHING/ LIGHTS**
Luces centelleantes

☐**FLOATERS**
Flotadores en visión

☐**GLAUCOMA**
Glaucoma

☐**GLARE**
Deslumbramiento

☐**LAZY EYE**
Ojo Perezoso

☐**RETINAL DETACHMENT**
Desprendimiento de Retina

☐**NONE**
Ninguno

Please list any other eye problems:
Enumere cualquier otro problema de sus ojos

_____

_____

_____

List all EYE surgeries:
Enumere todas las cirugías de sus OJOS

_____

_____

List all OTHER surgeries:
Enumere todas sus cirugías

_____

_____

Have you been hospitalized in the last 12 months? ☐**YES** ☐**NO**
¿Ha estado hospitalizado(a) en los últimos 12 meses? *SI* *NO*

If YES, list the reason and all dates:
Si lo estuvo, enumere las razones y fechas

_____

_____

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Do you have diabetes? ☐**YES** ☐**NO**
¿Tiene diabetes? *SI* *NO*

What type do you have? ☐**Type I (one)** ☐**Type II (two)**
¿Qué tipo de diabetes tiene? *Tipo 1* *Tipo 2*

If YES, How long have you been a diabetic? _____
Si es diabético, ¿hace cuánto que tiene diabetes?

Is your Diabetes controlled or uncontrolled? _____
¿Está su diabetes controlada o no?

What was your last Blood Sugar Level? _____
¿Cuál fue su último nivel de azúcar?

What was your last Hemoglobin A1C? _____
¿Cuál fue su último nivel de hemoglobina glicosilada (A1C)?

Do you use Insulin? ☐**YES** ☐**NO**
¿Utiliza insulina? *SI* *NO*

REVIEW OF SYSTEMS
Revisión de Sistemas

Please mark the box and or circle any persistent symptoms you have had in the past 6 months.
Por favor marque la casilla de cualquier síntoma que haya tenido en los últimos 6 meses:

Cardiovascular:

☐High Blood pressure
Presión Alta

☐Headaches
Dolor de Cabeza

☐Palpitations (fast or irregular heartbeat)
Palpitaciones (latidos rapidos o irregulares)

☐Fainting
Desmayos

☐Heart Attack
Infarto al Corazón

☐Chest Pain
Dolor de Pecho

☐No Problems
Ningún Problema

Constitutional:

☐Fever
Fiebre

☐Weight loss
Pérdida de peso

☐Fatigue
Fatiga

☐Loss of appetite
Pérdida de apetito

☐Chills
Escalofríos

☐No Problems
Ningún Problema

Ear/Nose/Throat
Oidos/Nariz/Garganta

☐Hearing Loss
Problemas de audición

☐Sore throat/Difficulties Swallowing
Dolor de garganta/Dificultad para deglutir

☐Runny Nose
Nariz congestionada

☐Dry Mouth
Sequedad de boca

☐Dizziness
Mareos

☐Nose Bleeds
Sangrado de Nariz

☐No Problems/*Ningún Problema*

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Nombre del Paciente *Fecha de Nacimiento* *Fecha*

Endocrine:
Endocrino

☐Excessive Thirst
Sed excesiva

☐Excessive Urination
Orina excesiva

☐Heat/Cold intolerance
Intolerancia al calor o frío

☐Hair Loss/Dry Skin
Caída de pelo/Sequedad de piel

☐No Problems
Ningún Problema

Gastrointestinal:

☐Abdominal Pain
Dolor Abdominal

☐Diarrhea
Diarrea

☐Nausea
Nausea

☐Bloody Stool
Sangre en sus heces

☐Mouth Sore/Ulcers
Úlceras o heridas en su boca

☐Stomach Ulcers
Úlceras en estómago

☐Constipation
Estreñimiento

☐Reflux
Reflujo/Acidez

☐No Problems
Ningún Problema

Genitourinary:
Genitourinario

☐Pain/Burning on Urination
Dolor o Ardor al Orinar

☐Blood in Urine
Sangre en la Orina

☐Bladder trouble
Problemas con Vejiga

☐Dialysis
Dialisis

☐Genital Sores/Ulcers
Úlceras o heridas en sus genitales

☐Impotence
Impotencia

☐Kidney Problems
Problemas con sus Riñones

☐No Problems
Ningún Problema

Hematology:
Hematológicos

☐Easy Bruising
Moretones con facilidad

☐Prolonged Bleeding
Sangrado prolongado

☐No Problems
Ningún Problema

Musculoskeletal:
Músculo esquelético

☐Muscle Aches
Dolor muscular

☐Joint Pain
Dolor de articulaciones

☐Muscle Cramps
Calambre muscular

☐Joint Swelling
Hinchazón de articulaciones

☐Back Pain
Dolor de espalda

☐Difficulty lying flat
Dificultad para acostarse de espalda

☐No Problems
Ningún Problema

Neurologic
Neurológico

☐Weakness
Debilidad

☐Scalp Tenderness
Dolor y sensibilidad en la sien

☐Stroke
Derrame Cerebral

☐Paralysis
Parálisis

☐Seizures or Convulsions
Convulsiones

☐Numbness/Tingle in Body
Endormecimiento u hormigueo en el cuerpo

☐Tremor
Tremor

☐No Problems/*Ningún Problema*

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Respiratory:
Respiratorio

☐Wheezing
Silbidos al respirar

☐Chronic Cough
Tos crónica

☐Coughing up blood
Tos con sangre

☐Shortness of Breath
Falta de aire

☐Severe of Frequent Colds
Resfrios severos o frecuentes

☐Difficulty Breathing
Dificultad para respirar

☐No Problems
Ningún Problema

Other systemic problems not listed above:
Otros problemas sistémicos que no fueron nombrados anteriormente

_____

_____

SOCIAL HISTORY
Historia Social

Smoking/Tobacco (Mark One)
¿Usted fuma? (Marque una de las respuestas a continuación)

☐**Never**
Nunca

☐**Former** **If you are a FORMER smoker, how long ago did you quit? _____**
Lo dejé *Si usted fumaba, ¿Hace cuánto dejó de fumar?*

How much did you smoke? _____packs per week
¿Cuánto fumaba? *cajetillas por semana*

☐**Current** **If CURRENTLY smoking _____packs per week**
Aún fumo *Si aún fuma* *cajetillas por semana*

Alcohol: ☐**None** ☐**1-2 per week** ☐**3-4 per week** ☐**7+ per week**
Nada *1-2 por semana* *3-4 por semana* *7+ por semana*

Substance Abuse: ☐**YES** ☐**NO**
Uso de drogas *SI* *NO*

Occupation: _____
Ocupación

Previous Occupation if retired: _____
Ocupación previa si ya está retirado

RETINA GROUP OF FLORIDA

Patient Name:_____ **Date of Birth:**_____ **Date:** _____
Nombre del Paciente *Fecha de Nacimiento* *Fecha*

<u>FAMILY HISTORY</u>: Indicate with an 'X' which blood relative has had the following diseases
Historia FamiliarIndique con una 'X' cual es el familiar que tiene las siguientes enfermedades

******* If you are adopted, please circle Adopted *******
Si usted es adoptado, por favor marque adoptado

Disease *Enfermedad*	**Mother** *Madre*	**Father** *Padre*	**Sister(s)** *Hermana(s)*	**Brother(s)** *Hermano(s)*	**Mom's Mom** *Abuela materna*	**Mom's Dad** *Abuelo materno*	**Dad's Mom** *Abuela paterna*	**Dad's Dad** *Abuelo paterno*	**Other** *Otro*
Adopted *Adoptado(a)*	**I do not know my family history** *No conozco mi historia familiar*								
Macular Degeneration *Degeneración Macular*									
Blindness *Ceguera*									
Congenital Cataract *Catarata Congénita*									
Glaucoma									
Retinal Detachment *Desprendimiento de Retina*									
Amblyopia *Ambliopía*									
Arthritis/Rheumatism *Artritis/Reumatismo*									
Cancer									
Diabetes									
Headaches/Migraines *Dolor de Cabeza/Migraña*									
Hypertension *Hipertensión*									
High Cholesterol *Colesterol Alto*									
Kidney Disease *Enfermedad Renal*									
Thyroid Disease *Enfermedad Tiroidea*									
Stroke *Derrame Cerebral*									
Uveitis/Iritis									
Heart Disease *Enfermedad Cardiaca*									
Genetic Disorders *Desordenes Genéticos*									
Bleeding or Clotting Disorder *Enfermedades de coagulación*									
Autoimmune Disease *Enfermedad Autoinmune*									
Asthma *Asma*									

PATIENT INFORMATION

Cell
Phone # (___) _____

Patient Name: _____ /_____/_____ **Phone # (___)_____**
(Last Name) (First name) (MI)

Guardian (if patient is a minor):_____ /_____/_____
(Last Name) (First Name) (MI)

Florida Address:. _____ **Apt #**_____
(Street)

_____ /_____/_____
(City) (State) (Zip)

Is this a Skilled Nursing Facility or Rehabilitation Facility? **Yes / NO**

Alternate Address:_____

E-Mail Address:_____

Date of Birth: _____ **Social Security:** _____**Sex: M / F**

PHARMACY NAME:_____ **PHONE NUMBER:**_____

ADDRESS:_____ **ZIP CODE:**_____

Primary
Insurance: _____ **ID #:** _____

Policy Holder's Name: _____

Secondary
Insurance: _____ **ID #:** _____

Policy Holders Name: _____

Employer: _____**Phone #:** _____

Spouse's Name: _____ **Birthday #:** _____

Emergency Contact: _____ **Phone #:** _____

Referring Eye Doctor:_____

_____/ _____ / _____
(Phone #) (City) (State)

Primary Care Doctor:_____

_____/ _____ / _____
(Phone #) (City) (State)

Patient Authorization to Release and/or Receive Information For the Purpose of Claim Payment.

I hereby authorize Retina Group of Florida, RGF physicians, and/or any RGF employees or agents to release any information regarding services rendered and allow a photocopy of my signature to be used to collect for services and file claims to my insurance company. I hereby give permission to contact any party listed on this form or in my medical chart to verify insurance, credit, or personal information. We want you to know that our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to always take reasonable precautions to protect your privacy, and want you to know that we support your full access to your personal medical record. I understand that I am responsible for my health insurance co-payments, deductibles, co-insurance, and non-covered services at the time services are rendered.

_____ _____

Patient Signature (Guardian Signature if Patient is a minor) **Date**

_____ _____

Print Patient Name **Date**

LIFETIME AUTHORIZATION

Medicare and Medicaid Patient Certification – Authorization to Release Information and Payment Request.

I certify that the information given by me in applying for payment under the TITLE XVII, of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physicians(s) services. I understand that I am responsible for my health insurance deductibles and co-insurance.

_____ _____

Patient Signature **Date**

_____ _____

Print Patient Name **Date**

PUPIL DILATION

Information and Consent

A portion of the complete eye examination which is performed in our office includes pupil dilation. This is essential for evaluation of your retinal condition. Pupillary dilation requires the placement of eyedrops which may last several hours.

Dilation creates difficulty focusing on near objects or reading material. Dilation may cause driving an automobile or operating heavy machinery to be dangerous.

Dilation of the pupils may rarely cause acute glaucoma. signs include redness, severe pain, nausea, or vision loss. If this occurs after dilation, please call our office immediately.

By signing below, I understand the above and give my consent for pupil dilation during my visits to this office.

_____ _____

Patient Name **Date**

RETINA GROUP OF FLORIDA
FINANCIAL AGREEMENT & ENDORSEMENT AUTHORIZATION

The fee for service is an obligation of the patient and is due at time of service. If you have medical insurance, our staff will assist you in obtaining the full allowable benefits from your insurance company. However, in the event the insurance company refuses previously confirmed coverage or reimburses a lesser amount than the charged, the patient is fully responsible for the entire obligation. Any service not covered by your insurance company must be paid at the time of service.

I fully understand that I am directly and fully responsible to Retina Group of Florida for all medical bills submitted by RGF, or its agents, for services rendered to me. I further agree to allow Retina Group of Florida to release any information necessary to process any medical claims rendered on my behalf. I further authorize payment of medical benefits to Retina Group of Florida for serviced rendered. I have read the above and fully understand its contents and all of my questions have been answered. I hereby agree to render payments in accordance with the terms and conditions set forth, and agree to collection fees, interest, court and attorney fees in order to collect any outstanding balances.

I (we) the undersigned hereby authorize Retina Group of Florida and its agents to endorse by (our) name, any medical drafts received form third party payers.

Authorizes Signature_____ **Date** _____

Print Name _____ **Relationship** _____

Witness _____

HIPAA Notice of Privacy Practices

_____Name

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or requires by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical and mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other used required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law; Public Health issues as required by law; communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, And Organ Donation; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; Inmates; Required uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposed as described in this Notice of Policy Practices. Your request must state the specific restriction and whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another health care professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have you physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any , of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filling a complaint.

This Notice was published and becomes effective on/or before April 14, 2003.

We are required by Law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA compliance officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of Our Privacy Practices:

Print Name:_____ **Signature:** _____ **Date:** _____

Patient Authorization for Use and Disclosures of Protected Health Information to Third Parties

_____

Name of Practice

Section must be completed for all authorizations

I hereby authorize the use of disclosure of my individually protected health information. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name:_____

ID Number:_____

Persons/Organizations Receiving Information:

Name	Relationship	Phone

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on ____/___/_____ (MM/DD/YYYY) Initials: _____
2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any effect on any actions they took before they received the revocation.
   Initials: _____

_____ _____

Signature of patient or representative Date
(Form MUST be completed before signing)
Printed name of patient's representative:_____
Relationship to patient:_____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION