*****PLEASE COMPLETE AND MAIL BACK PRIOR TO YOUR APPOINTMENT*****

VITREO-RETINAL CONSUL TANTS & SURGEONS, P.A.
530 N. Lorraine
Wichita, KS 67214
316-683-5611

Appointment Date: ____________ Time: ___________

Physician: ______________________ Location:____________________

PATIENT INFORMATION

NAME (LAST, FIRST, MIDDLE)	MARITAL STATUS	SSN#	DATE OF BIRTH	SEX

PREFERRED LANGUAGE	RACE: ❑ AMERICAN INDIAN/ALASKAN ❑ ASIAN ❑ BLACK OR AFRICAN AMERICAN ❑ DECLINE TO SPECIFY ❑ NATIVE HAWAIIAN OR PACIFIC ISLANDER ❑ WHITE
LOCAL ADDRESS	ETHNICITY: ❑ DECLINE TO SPECIFY ❑ HISPANIC OR LATINO ❑ NOT HISPANIC OR LATINO ❑ UNKNOWN
CITY, STATE, ZIP	
HOME PHONE	
CELL PHONE / ALTERNATE PHONE	
EMAIL	
SECONDARY/BILLING ADDRESS (if Applicable)	
CITY, STATE, ZIP	

PRIMARY EMPLOYER	OCCUPATION
ADDRESS	WORK PHONE
CITY, STATE, ZIP	

SPOUSE OR GUARANTOR

NAME (LAST, FIRST, MIDDLE)	MARITAL STATUS	SSN#	DATE OF BIRTH	SEX

RELATIONSHIP TO PATIENT	OCCUPATION
ADDRESS	EMPLOYER
PHONE	EMPLOYER ADDRESS

EMERGENCY CONTACT

NAME	HOME PHONE	
WORK PHONE	CELL PHONE	ALTERNATE PHONE

Patient Name:______________________________DOB: ____________________

PRIMARY INSURANCE	
NAME OF INSURANCE COMPANY	POLICY NUMBER
NAME OF INSURED	GROUP#
RELATIONSHIP TO PATIENT	DATE OF BIRTH

SECONDARY INSURANCE	
NAME OF INSURANCE COMPANY	POLICY NUMBER
NAME OF INSURED	GROUP#
RELATIONSHIP TO PATIENT	DATE OF BIRTH

PHYSICIANS	
REFERRING PHYSICIAN	PHONE
REFERRING ADDRESS	
EYE DOCTOR	PHONE
EYE DOCTOR ADDRESS	
FAMILY PHYSICIAN	PHONE
FAMILY PHYSICIAN ADDRESS	
PHYSICIAN MANAGING DIABETES (if applicable)	PHONE
PHYSICIAN MANAGING DIABETES ADDRESS	

*****If this visit is related to an accident, please provide information below*****

Accident Date: ____________________

Accident Details (include which eye): ____

____

____

Is This a Work Comp Injury? _______ **Yes** _______ **No**

If Yes, Please Provide A Contact Name And Phone Number At Your Place Of Employment: ____

____

Patient Name:________________________________ DOB: ____________________

MEDICAL HISTORY

Please circle Yes or No if you have been diagnosed with the following:

	Circle	Year Diagnosed
High Cholesterol	yes no	____________
High Blood Pressure	yes no	____________
Heart Valve Disease	yes no	____________
Heart Disease	yes no	____________
Asthma	yes no	____________
COPD	yes no	____________
Inflammatory Disease	yes no	Type:____________
Arthritis	yes no	____________
Rheumatoid Arthritis	yes no	____________
Headaches	yes no	____________
Migraines	yes no	____________
Sleep Apnea	yes no	C-Pap? ____________
Irregular Heartbeat	yes no	____________
Heart Attack	yes no	____________
Stroke	yes no	____________
Multiple Sclerosis	yes no	____________
Cancer	yes no	Type:____________
Hepatitis	yes no	Type:____________
HIV/AIDS	yes no	____________
Lupus	yes no	____________
Thyroid Disease	yes no	____________
Diabetes	yes no	Type I or Type II Year Diagnosed:____________
Dementia	yes no	____________
Alzheimer’s	yes no	____________
GERD	yes no	____________
GOUT	yes no	____________
Parkinson’s Disease	yes no	____________
Sarcoidosis	yes no	____________
Enlarged Prostate	yes no	____________
Bell’s Palsy	yes no	____________

Patient Name:____DOB: ______________________

SURGICAL HISTORY

Procedure	Date Performed	Doctor
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

EYE HISTORY (surgeries, injuries, etc.)

Procedure / Injury	Date	Doctor
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Patient Name:______________________________ DOB:______________

MEDICATION RECORDS

Pharmacy:______________________________ Phone: ______________

Address: ______________________________

Medication/Dosage and/or Over the Counter Vitamins/Herbal Supplements				Medical Condition	Updated Date Initial
NAME	STRENGTH	DOSE	HOW OFTEN		
EXAMPLE: Lisinopril	40mg	1 tablet	1 x day	Blood Pressure	

DRUG ALLERGIES & REACTIONS

Please describe reaction in space provided

❑ NO KNOWN DRUG ALLERGIES

❑ PENICILLIN ______________________

❑ TETRACAINE ______________________

❑ SULFA ______________________

❑ IODINE ______________________

❑ CODEINE ______________________

❑ TAPE/ADHESIVE ______________________

❑ LATEX ______________________

❑ ______________________

❑ ______________________

❑ ______________________

Patient Name:______________________________ DOB: ____________________

FAMILY MEDICAL HISTORY (e.g. father, mother, siblings, grandparents)

SYSTEMIC	**Circle**	**Who? (excluding self)**
Diabetes	yes no	____________________
Heart Disease	yes no	____________________
High Blood Pressure	yes no	____________________
Stroke	yes no	____________________
Cancer	yes no	____________________
Rheumatoid or Arthritis	yes no	____________________
Thyroid disease	yes no	____________________
Headaches / Migraines	yes no	____________________

OCULAR	**Circle**	**Who? (excluding self)**
Blindness	yes no	____________________
Crossed / Lazy eyes	yes no	____________________
Glaucoma	yes no	____________________
Cataracts	yes no	____________________
Retinal Detachment	yes no	____________________
Macular Degeneration	yes no	____________________

SOCIAL HISTORY

Tobacco Use: ❑ Never Smoker ❑ Former Smoker ❑ Current Every day Smoker

❑ Current Some Day Smoker ❑ Chewing Tobacco

Alcohol Use: ❑ None ❑ Occasional/Social ❑ 1-2 Drinks/Day ❑ 3-4 Drinks/Day

Substance Abuse: ❑ Yes ❑ No ❑ Formerly

Currently Driving? ❑ Yes ❑ No

Please sign and date below:

Patient Signature:______________________________ **Date:**____________________

Patient Name:______________________________________ DOB:________________

Vitreo-Retinal Consultants

Patient Consent Form (Please Read and Sign)

I hereby assign the insurance benefits due me under my insurance carrier to ***Vitreo-Retinal Consultants***. I understand that I am financially responsible for any charges not covered by this assignment. I also hereby authorize the release of information required in the course of my examination or treatment as may be needed to process my insurance.

Medicare Patients: I request that payment of authorized Medicare benefits be made to ***Vitreo-Retinal Consultants*** for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I acknowledge that I have been given ***Vitreo-Retinal Consultants*** Notice of Privacy Practices. I understand that if I have questions that I should contact the Privacy Official.

A photocopy of this consent shall be considered as valid as the original.
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

X ____ ____________________

Patient (or Responsible Party) Signature *Date*

Insurance card and Photo ID are required at check-in. Please be prepared to pay any co-payments that are required by your insurance. Please note that you will be responsible for the balance after your insurance claim has been processed. For your convenience, VISA, MasterCard, and Discover are accepted.

- It is ***your*** responsibility to check with your insurance company prior to your first visit to determine if we are a participating physician with your insurance plan.
- If your insurance plan requires you to have a referral from your primary physician, ***you*** are responsible for contacting your physician before each visit to our office. Please ask your physician to fax or mail a copy of the referral to our office prior to your visit. If you do not have an authorized referral, we will not refuse you care. However, our office and your insurance company recognize that without a referral, you are responsible for any charges related to services provided. We will bill you directly for charges not covered by a referral.

Disclosure: I hereby allow ***Vitreo-Retinal Consultants*** to communicate with the following people in regards to my medical treatment, account information, and appointment information: ____________________ Relation: ___________

____________________ Relation: ___________

____________________ Relation: ___________

____________________ Relation: ___________

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

X ____ ____________________

Patient (or Responsible Party) Signature *Date*