RETINA GROUP OF FLORIDA

PLEASE FILL OUT ALL FOUR (4) PAGES

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Family/Primary Doctor/Internist: _____ **Eye Doctor:** _____

List ALL medical problems: _____

_____

List ALL prescribed medications with dosage:

_____

_____

_____

Have you received a Pneumonia Vaccination? YES NO **If YES, Date of vaccination:** _____

Have you received a Flu Vaccination? YES NO **If YES, Date of vaccination:** _____

LIST ALL EYE DROPS:

_____

_____

PAST EYE HISTORY

CIRCLE ALL THAT APPLY

GLAUCOMA	LAZY EYE
FLOATERS	GLARE
EYE INJURY/TRAUMA	CATARACT
FLASHING LIGHTS	DISTORTION
RETINAL DETACHMENT	NONE

Do you have any ALLERGIES to medications *or* eye drops?
YES NO

If YES, list the medications and/or eye drops:

_____

_____

Please list any other eye problems: .

_____

_____

_____

List all EYE surgeries: _____

_____

List all OTHER surgeries: _____

Have you been hospitalized in the last 12 months? YES NO

If YES, list the reason and all dates:

_____

_____

Do you have diabetes? YES NO

What type do you have? Type I (one) Type II (two)

If YES, How long have you been a diabetic? _____

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Is your Diabetes controlled or uncontrolled? _____

What was your last Blood Sugar Level? _____

What was your last Hemoglobin A1C? _____

Do you use Insulin? : YES NO

REVIEW OF SYSTEMS: Please mark the box and or circle any persistent symptoms you have had in the past 6 months. List other concerns below:

Cardiovascular:

- __ High Blood pressure
- __ Headaches
- __ Palpitations (fast or irregular heartbeat)
- __ Fainting
- __ Heart Attack
- __ Chest Pain
- __ No Problems

Constitutional:

- __Fever
- __ Weight loss
- __ Fatigue
- __ Loss of appetite
- __ Chills
- __ No Problems

Endocrine:

- __ Excessive Thirst
- __ Excessive Urination
- __Heat/Cold Intolerance
- __ Hair Loss/ Dry Skin
- __ No Problems

Gastrointestinal:

- __ Abdominal Pain
- __ Diarrhea
- __ Nausea
- __ Bloody Stool
- __ Mouth Sores/Ulcers
- __ Stomach Ulcers
- __ Constipation
- __ Reflux
- __ No Problems

Genitourinary:

- __ Pain/Burning on Urination
- __ Blood in Urine
- __ Bladder trouble
- __ Dialysis
- __ Genital Sores/ Ulcers
- __ Impotence
- __ Kidney Problems
- __ No Problems

Hematology:

- __ Easy Bruising
- __ Prolonged Bleeding
- __ No Problems

Ears/Nose/Throat:

- __ Hearing Loss
- __ Sore throat/ Difficulty Swallowing
- __ Runny Nose
- __ Dry Mouth
- __ Dizziness
- __ Nose Bleeds
- __ No Problems

Skin/Integumentary:

- __ Rash
- __ Skin Sores
- __ Skin Cancer
- __ Warts
- __ Mouth Ulcers
- __ Café au lait spots
- __ No Problems

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Musculoskeletal:

- __ Muscle Aches
- __ Joint Pain
- __ Muscle Cramps
- __ Joint Swelling
- __ Back Pain
- __ Difficulty Laying Flat
- __ No Problems

Neurologic:

- __ Weakness
- __ Scalp Tenderness
- __ Stroke
- __ Paralysis
- __ Seizures or Convulsions
- __ Numbness/Tingle in Body
- __ Tremor
- __ No Problems

Respiratory:

- __ Wheezing
- __ Chronic Cough
- __ Coughing up blood
- __ Shortness of Breath
- __ Severe or Frequent Colds
- __ Difficulty Breathing
- __ No Problems

Other systemic problems not listed above:

_____

_____

RETINA GROUP OF FLORIDA

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Patient Name: _____ Date of Birth: _____ Date: _____

SOCIAL HISTORY

Smoking/Tobacco: (Circle One)

Never

Former If you are a FORMER smoker, how long ago did you quit? _____

How much did you smoke? _____ packs per week

Current If CURRENTLY smoking _____ packs per week

Alcohol: None 1-2 per week 3-4 per week 7+ per week

Substance Abuse: YES NO

Occupation : _____

Previous Occupation if retired: _____

FAMILY HISTORY : Indicate with an 'X' which blood relative has had the following diseases.

******If you are adopted, please circle Adopted ******

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other
Adopted	I do not know my family history.								
Macular Degeneration									
Blindness									
Congenital Cataract									
Glaucoma									
Retinal Detachment									
Amblyopia									
Arthritis/Rheumatism									
Cancer									
Diabetes									
Headaches/Migraines									
Hypertension									
High Cholesterol									
Kidney Disease									
Thyroid Disease									
Stroke									
Uveitis/ Iritis									
Heart Disease									
Genetic Disorders									
Bleeding or Clotting Disorder									
Autoimmune Disease									
Asthma									

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS FORM.

RETINA GROUP OF FLORIDA

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 Holder's Name: _____

Employer: _____ **Phone #:** _____

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

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

Referring Eye Doctor: _____

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

Primary Care Doctor: _____

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

Please Sign Reverse Side

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 any non-covered services at the time services are rendered.

Patient Signature (Guardian Signature if Patient is a Minor) _____ Date _____

Print Patient Name _____ Witness _____

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 a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and co-insurance.

Patient Signature _____ Date _____

Print Patient Name _____ Witness _____

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Barry S. Taney, MD
Lawrence S. Halperin, MD
W. Scott Thompson, MD
Patrick E. Rubsamen, MD
Scott R. Anagnoste, MD
Krista Rosenberg, MD
Mandeep S. Dhalla, MD
Kevin Kelly, MD
Mario del Cid, MD
Darin R. Goldman, MD
Eduardo Uchiyama, MD

PUPIL DILATION

Information and Consent

Correspondence
Fort Lauderdale
5601 N. Dixie Hwy,
Suite 307
Fort Lauderdale, FL 33308
FAX: 954-776-6895
TEL: 954-776-6880

Boca Raton
950 Glades Rd.
Suite 1-C
Boca Raton, FL 33431
FAX: 561-391-6004
TEL: 561-394-6499

Boynton Beach
8199 Jog Rd.
Suite 250
Boynton Beach, FL 33472
FAX: 561-737-8335
TEL: 561-737-1355

Hollywood
4000 Hollywood Blvd.
Suite 199-N
Hollywood, FL 33021
FAX: 954-894-4822
TEL: 954-894-7020

Plantation
1776 N. Pine Island Rd.
Suite 312
Plantation, FL 33322
FAX: 954-452-2027
TEL: 954-452-4500

Wellington
1397 Medical Park Blvd.
Suite 240
Wellington, FL 33414
FAX: 561-784-3855
TEL: 561-784-3788

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 loss of vision. 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

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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 you insurance company. However, in the event the insurance company refuses previously confirmed coverage or reimburses a lesser amount than 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 services 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 from third party payers.

Authorized Signature _____ Date _____

Print Name _____ Relationship _____

Witness _____

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HIPAA Notice of Privacy Practices

_____Name

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND 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 required 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 physicial or 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 use 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 also call you by name in the waiting room when your physician is ready to see you. 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; Workers' 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 also 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 purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction and to 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 Healthcare 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 copy 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 your 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 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 filing 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:_____

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HIPAA COMPLIANT MEDICAL AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

To whom it may concern:

I, _____, _____
Name Address, City, State, Zip Code

hereby authorize the release of all medical documentation and other information, including protected health information that I could personally obtain upon request, which may be in the possession of any health care provider, medical care facility, insurer, physician, hospital, ambulance service or nurse or any other covered entity under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to

_____, _____
Name Address, City, State, Zip Code

_____, _____
Name Address, City, State, Zip Code

regarding my complete medical history and physical & mental condition both prior to and subsequent to the date of this authorization, regardless of lapsed time. The person(s) named above is/are hereby designated as my "personal representative(s)" as that term is used within HIPAA.

I intend the person(s) listed above to have authority to gain immediate access to my medical records.

Upon presentation of this authorization (or a photocopy), you are authorized to release a copy of these records to any person who is my personal representative. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the personal representative and may no longer be protected by federal law.

The purpose of the disclosure is to enable the person(s) named above to fully act as my personal representative under HIPAA, including the ability to access and re-release my medical records. This authorization shall be deemed to comply with all requirements of HIPAA (45 CFR Section 164).

This authorization shall become effective on the date it is signed and expire two years after my death. I understand that I may revoke this authorization at any time, without regard to my mental or physical condition, by sending written notice to my medical providers or by using any method capable of revoking a health care agency under Illinois law.

Signature of person authorizing disclosure:

_____ _____
Date

Witnessed on the date noted above by: _____ _____
Signature of witness #1 Signature of witness #2

_____ _____
Print name of witness #1 Print name of witness #2

Witnesses should not be any of the persons listed above or heirs of mine.

You may refuse to sign this authorization form.