



# 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



Excellence  
Compassion  
Vision

Retina Group of Florida  
New Patient Medical History

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

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Family/Primary Doctor/Internist: \_\_\_\_\_ Eye Doctor: \_\_\_\_\_

List all Medications (including Aspirin and EYEDROPS) you currently take: \_\_\_\_\_

Do you have ALLERGIES to any medications or eyedrops? YES NO  
If YES, list the medications: \_\_\_\_\_

List all MEDICAL Problems: \_\_\_\_\_

List all EYE Problems: \_\_\_\_\_

List all SURGERIES or LASER TREATMENT you have had (cataract, gall bladder, etc): \_\_\_\_\_

Have you ever been hospitalized? YES NO  
If YES, list reason and all dates: \_\_\_\_\_

**PAST EYE HISTORY**

CIRCLE ALL THAT APPLY

GLAUCOMA LAZY EYE

FLOATERS GLARE

CATARACT EYE INJURY

RETINAL DETACHMENT

FLASHING LIGHTS

DISTORTION NONE

**MEDICAL PROBLEMS**

	YES	NO	Details
<b>EYES</b> (poor vision, eye pain, tearing, redness, etc.)			
<b>General</b> (fever, fatigue, weight loss, weight gain, etc.)			
<b>EARS, NOSE, THROAT</b> (hearing, dry mouth, dizziness, nosebleeds, difficulty swallowing, hoarseness, etc.)			
<b>HEART/VESSELS</b> (high blood pressure, headaches, racing pulse, fainting, heart attack, chest pains, carotid surgery, etc.)			
<b>RESPIRATORY</b> (short of breath, wheezing, asthma, chronic cough, lung cancer, emphysema, Tuberculosis, etc)			
<b>GASTROINTESTINAL</b> (stomach ulcers, reflux, diarrhea, constipation, hernia, jaundice, blood in stools, etc.)			
<b>GENITOURINARY</b> (painful urination, frequent urination, bloody urine, impotence, dialysis, HIV, hepatitis C, syphilis, etc.)			
<b>ORTHOPEDIC</b> (joint pain or stiffness, joint swelling, gout, muscle cramps, arthritis, etc.)			
<b>SKIN</b> (rashes, warts, pimples, mouth ulcers, painful skin nodules, café au lait spots, tick bites, etc.)			
<b>NEUROLOGIC</b> (seizures, numbness, stroke, paralysis, etc.)			
<b>PSYCHIATRIC</b> (anxiety, claustrophobia, depression, etc.)			
<b>ENDOCRINE</b> (diabetes, thyroid gland, etc.)			
<b>BLOOD</b> (bleeding, high cholesterol, anemia, blood transfusions, leukemia, lymphoma etc.)			
<b>IMMUNE</b> (HIV, Lupus, hives, itchy skin, eczema, etc.)			
<b>FEMALES</b> ( history of breast cancer, are you pregnant? Nursing? )			

**Family History:** MOTHER, FATHER, GRANDPARENTS, SIBLINGS, CHILDREN

CIRCLE ALL THAT APPLY  
 NONE      CATARACT    GLAUCOMA    DIABETES    NIGHT BLINDNESS  
                  RETINAL DETACHMENT    MACULAR DEGENERATION  
                  CANCER    ARTHRITIS    HEART ATTACK    STROKE

**Social History:**

Smoke cigarettes? \_\_\_\_\_ packs per week    NO  
 Drink alcohol? \_\_\_\_\_ drinks per week    NO  
 Drive an automobile?    YES    NO  
 Had a blood transfusion?    YES    NO

**FOR OFFICE USE ONLY**

The above history has been completely reviewed by \_\_\_\_\_, MD \_\_\_\_\_

Updated \_\_\_\_\_, MD \_\_\_\_\_ Date \_\_\_\_\_  
 Updated \_\_\_\_\_, MD \_\_\_\_\_ Date \_\_\_\_\_  
 Updated \_\_\_\_\_, MD \_\_\_\_\_ Date \_\_\_\_\_  
 Updated \_\_\_\_\_, MD \_\_\_\_\_ Date \_\_\_\_\_