Retina Group of Florida™

New Patient Paperwork

Date *(Fecha)*:_____

Patient Name *(Nombre del paciente)*:_____

D.O.B.:_____ Social Security *(Seguridad Social)*:___-_____-_____ Sex: M F

Marital Status:_____ Race:_____ Primary Language:_____

Ethnicity:_____ *Hispanic or Latino* _____*Non-Hispanic or Latino* _____ *Decline to Answer*

Address *(Direccion)*:_____

Street *(Calle)* City*(Ciudad)* State*(Estado)* Zip*(Cremallera)*

Home Phone *(Telefono de casa)*:_____

Cell Phone *(Telefono movil)*:_____

E-mail Address *(Direccion de correo electronico)*:_____

Are you currently in a Skilled Nursing or Rehab Facility? *(¿Se encuentra actualmente en un centro de enfermería especializada o de rehabilitación?)* Yes / No

Skilled Nursing / Rehab Facility Name:_____

Pharmacy Name:_____ Pharmacy Phone#:_____

Pharmacy Address:_____

Primary Insurance:_____ Policy ID:_____

Policy Holder's Name (if different than patient):_____

Secondary Insurance:_____Policy ID:_____

Employer:_____ Phone:_____

Emergency Contact:_____ Phone:_____

Relationship:_____

Referring Eye Doctor:_____ Phone:_____

Referring Eye Doctor Address:_____

Primary Care Doctor:_____ Phone:_____

Primary Care Doctor Address:_____

Have you received a Pneumonia Vaccination? Yes No Date Received:_____

Have you received a Flu Vaccination? Yes No Date Received:_____

Have you received a COVID Vaccination? Yes No Date Received:_____

Medical History *(Historial medico)*

Do you have Diabetes? Yes No If Yes, What type? Type I Type II

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

What was your last Blood Sugar Level?

What was your last Hemoglobin A1C?

Insulin Dependent? Yes No

Social History *(Historia Social)*

Are you a smoker? *(Eres Fumadoro?)* Yes No Tobacco and/or Marijuana

Never *(Nunca)* Former Smoker *(Ex fumadoro)*

If you are a FORMER smoker, how long ago did you quit?_____ Years/Months *(Anos/Meses)*
(Si usted es un EX fumador, ¿hace cuánto tiempo que lo dejó?)

Current Smoker/Tobacco Use *(Fumador/tabaco actual)*

_____Packs Per Day *(Paquetes por dia)* ____Vape *(Vapear)* _____Dipping *(Inmersion)*

Alcohol: None 1-2/Week 3-4/Week 7+/Week

Substance Abuse: *(Abuso de sustancias):* _____Yes _____No

Current Occupation (*Ocupación actual*):_____

If Retired, Previous Occupation (*Ocupación previa si ya está retirado*):_____

Past Eye History: (Y or N)

	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*

Medical History *(Historial medico)*

Have you been diagnosed with HIV? Yes _____ No_____

Have you been diagnosed with Hepatitis? Yes _____ No_____

Have you been diagnosed with COVID recently? Yes _____ No_____

If Yes, When? _____

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? *(¿Ha estado hospitalizado(a) en los últimos 12 meses?):*

Yes No If yes, Reason for Hospitalization and Dates *(En caso afimativo, motive de la hospitalizacion y fechas)*: _____

_____

_____

Do you have any ALLERGIES to medications *(*¿Tiene alguna ALERGIAS a medicamentos?)?

Yes No

Medication Allergy *(Alergia a medicamentos)*	**Reaction** *(Reaccion)*

Eye Medication *(Medicacion para los ojos)* **(Drops/Ointments)**	**Dose** *(Dosis)* **(i.e. 100 mg)**	**Times / Day** **(***Horarios/Dia)*	**Right, Left, Both** *(Derecha, Izquierdo, ambos)*

List ALL Medications you are currently taking *(Enumere TODOS los medicamentos que esta tomando actualmente)***:**

Medication Name *(Nombre del medicamento)*	**Dose** *(Dosis)* **(i.e. 100 mg)**	**Times / Day** **(***Horarios/Dia)*	**Administration Route** ***(****Ruta de administracion)* **(by mouth, topical, inj., etc.)**