MONMOUTH RETINA | NATIONAL DIABETIC EYE CENTER

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I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE/MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF, MONMOUTH RETINA CONSULTANTS FOR ANY SERVICES FURNISHED TO ME BY THE PHYSICIANS OR SUPPLIER. I GIVE AUTHORIZATION TO ANY HOLDER OR MEDICAL INFORMATION CONCERNING ME TO RELEASE INFORMATION NEEDED TO DETERMINE THE BENEFITS PAYABLE FOR RELATED SERVICES TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS.

INSURANCE/MEDICARE WILL ONLY PAY FOR SERVICE THAT IT CONSIDERS TO BE MEDICALLY "REASONABLE AND NECESSARY." IF INSURANCE/MEDICARE DETERMINES THAT A PARTICULAR SERVICE, ALTHOUGH OTHERWISE COVERED, IS NOT "REASONABLE AND NECESSARY" UNDER ITS STANDARDS IT WILL DENY PAYMENT FOR THAT SERVICE. I WISH TO HAVE SERVICES PROVIDED BY RUPAN TRIKHA, M.D., CHIRAG V. PATEL, M.D., SANA IDREES, M.D., KONSTANTIN ASTAFUROV, M.D., PHD, JOSEPH J. RAEVIS, MD AND MEGHAN L. POWNER, PA-C THEREFORE I AGREE THAT, IF INSURANCE/MEDICARE DENIES PAYMENT FOR THESE SERVICES I SHALL REMAIN PERSONALLY RESPONSIBLE FOR ANY BALANCE DUE.

I UNDERSTAND THAT MY PUPILS WILL BE DILATED AND MY VISION WILL BE BLURRY AFTERWARDS, THEREFORE I MAY BE UNABLE TO DRIVE.

I UNDERSTAND THAT IF MEDICALLY NECESSARY FOR A DIAGNOSIS, TESTING, SUCH AS FLUORESCEIN ANGIOGRAM, ULTRASOUND, VISUAL FIELD EVALUATION, AND OTHER OPTIC NERVE AND RETINAL EVALUATIONS MAY BE PERFORMED WITH MY INFORMED CONSENT.

AFTER MY DOCTOR REVIEWS THE RISKS AND BENEFITS OF ANY NECESSARY PROCEDURES WITH ME DURING MY CONSULTATION, I GIVE PERMISSION FOR OPHTHALMIC LASER TREATMENTS, CRYOTHERAPY, INTRAVITREAL INJECTIONS OF DYES AND MEDICATIONS AND/OR INTRAOCULAR INJECTIONS OF MEDICATIONS AND GASES.

I AM AWARE THAT I AM RESPONSIBLE FOR ANY OUTSTANDING BALANCE NOT PAID BY MY INSURANCE COMPANY.

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I WAS OFFERED THE **NOTICE OF PRIVACY PRACTICES** FOR THE PRACTICE OF MONMOUTH RETINA CONSULTANTS TO READ, AND IF I CHOOSE TO KEEP AND TAKE WITH ME.

Print Name _____ **Date** _____

Signature _____

Patient Registration:

First Name:_____ **Last Name:**_____ **Middle Initial**____

Date of Birth:_____ **Social Security #**_____-_____-_____

Sex assigned at birth: ☐ Male ☐ Female ☐ Declined to Specify

Pronouns: ☐ He/him/his ☐ She/her/her ☐ They/them/their ☐ Decline to specify

Preferred Language: ☐ English ☐ Spanish ☐ Portuguese ☐ Russian ☐ Other

Race: ☐ Asian ☐ Black and/or African American ☐ White/Caucasian ☐ Decline to specify

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Specify

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Address (Street or Box**):**_____ **Apt#:**_____

City:_____ **State:**_____ **Zip Code**_____

Home Phone #:_____ **Cell #:**_____ **Work #:**_____

Preferred Contact: ☐ Home ☐ Cell ☐ Work

Email:_____

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

Relation to Patient: ☐ Spouse ☐ Partner ☐ Parent ☐ Sibling ☐ Child ☐ Other:_____

Do we have permission to discuss your health care with this person? ☐ Yes ☐ No

Primary Health Insurance: ☐ Yes ☐ No ☐ Self-Pay

Secondary Health Insurance: ☐ Yes ☐ No ☐ Self-Pay

Complete this section if the patient is a Minor or has a Legal Guardian

Primary Health Insurance Guarantor's Name:_____ ☐ Self

Date of Birth (**Policy Holder**):_____ **Relation to Patient:**_____

Secondary Health Insurance Guarantor's Name:_____ ☐ Self

Date of Birth (**Policy Holder**):_____ **Relation to Patient:**_____

Do you have a healthcare proxy? ☐ Yes ☐ No – if yes, please provide us a copy of your healthcare proxy for your medical records.

Is patient residing in a Skilled Nursing Facility / Rehab Center? ☐ Yes ☐ No – if yes, Name of Facility:

_____ City:_____ Phone #:_____

Referring Physician:_____

Location:_____Phone #:_____

Reason for today's visit?_____

Regular Ophthalmologist/Optometrist:_____

Location:_____ Phone #:_____

Primary Care Physician:_____ Phone #:_____

Location/Zip Code:_____ Fax#:_____

Endocrinologist:_____ Phone #:_____

Location/Zip Code:_____ Fax#:_____

Cardiologist:_____ Phone #:_____

Location/Zip Code:_____ Fax#:_____

Rheumatologist:_____ Phone #:_____

Location/Zip Code:_____ Fax#:_____

Pharmacy Information:_____ Phone #:_____

Location/Zip Code:_____ Fax #:_____

Medical History *please **CIRCLE** and **CHECK** all that apply *

Yes/No Diabetes ☐ **Type I** ☐ **Type II**	**Yes/No** Thyroid ☐ **Hyper** ☐ **Hypo**
Yes/No Insulin Dependent	**Yes/No** ☐ Alzheimer's ☐ Dementia
Yes/No Hypertension (Blood Pressure)	**Yes/No** ☐ HIV ☐ AIDS
Yes/No ☐ **High** Cholesterol ☐ **Low** Cholesterol	**Yes/No** Hepatitis ☐ **A** ☐ **B** ☐ **C**
Yes/No ☐ Heart Issues ☐ Congestive Heart Failure	**Yes/No** ☐ Stroke ☐ Bell's Palsy
Yes/No Arthritis ☐ Rheumatoid ☐ Psoriatic ☐ Gout	**Yes/No** ☐ Cancer ☐ Melanoma
Yes/No ☐ Asthma ☐ COPD	**Yes/No** ☐ Migraines ☐ Lyme Disease
Yes/No Kidney ☐ Disease ☐ Dialysis ☐ Stones	**Yes/No** Sickle Cell Disease
Yes/No ☐ Lupus ☐ Multiple Sclerosis	**Yes/No** Fibromyalgia
Yes/No ☐ Sjogren Syndrome ☐ Graves' Disease	**Yes/No** ☐ Crohn Disease ☐ IBS
Yes/No ☐ Myasthenia Gravis ☐ Anemia	**Yes/No** Other:

Surgical History

Have you had any other surgeries unrelated to your eyes? ☐ Yes ☐ No if yes, please list details below

	Date
	Date
	Date

List ALL Medications that you are currently taking? *If you have a list, we can take a copy*

Medication Name/Dosage	**Frequency**	**Reason?**

Are you using any **EYE DROPS**? ☐ Yes ☐ No *if yes, please list **ALL** drops or we can take a copy*

Name	**Dosage**	**Which Eye**	**Frequency**
		R / L / Both	
		R / L / Both	
		R / L / Both	
		R / L / Both	
		R / L / Both	

Are you **allergic** to any medications? ☐ Yes ☐ No *if yes, please list **ALL** allergies below*

	Reaction?	
	Reaction?	
	Reaction?	
	Reaction?	

Are you **allergic** to any substance or food? ☐ Yes ☐ No *if yes, please list **ALL** allergies below*

	Reaction?	
	Reaction?	
	Reaction?	

Family History (Immediate Family**)** ***please check **ALL** that apply and specify which relative**

Is there a family history of	**Yes**	**No**	
Diabetes?			Relative
Hypertension?			Relative
Glaucoma?			Relative
Macular Degeneration?			Relative
Retinal Disease?			Relative
Retinal Detachment?			Relative
Cataracts?			Relative
Headaches/Migraines?			Relative
Other?			Relative

Social History ***please check **ALL** that apply**

Do you smoke? ☐ Current ☐ Former ☐ Never Do you vape? ☐ Yes ☐ No			
Do you drink alcohol? ☐ Rarely ☐ Socially ☐ Frequently ☐ Never			
Marital Status? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed			
Do you use recreational drugs? ☐ Yes ☐ No ☐ Never | Other			
Occupation? ☐ Retired ☐ Working ☐ Not Working ☐ Disabled ☐ Unemployed			
Do you drive? ☐ Yes ☐ No			
Living Conditions? ☐ Lives alone ☐ With Family/Spouse ☐ Nursing Home ☐ Retirement Center			
For Age 65+ (PMHx) Are you a fall risk? ☐ Yes ☐ No			
Are you adopted? ☐ Yes ☐ No			
Are you on hospice? ☐ Yes ☐ No			
Were you born pre-maturely? ☐ Yes ☐ No			
Did you receive your flu vaccination? ☐ Yes ☐ No ☐ Never | Date?			
Did you receive your pneumonia vaccination? ☐ Yes ☐ No ☐ Never | Date?			
Did you receive the covid vaccine? ☐ Yes ☐ No ☐ Booster? How many? ☐ Moderna ☐ Pfizer ☐ Johnson & Johnson			
Dates?			
Dates?			

Review of Symptoms *please check **ALL** that apply*

Allergy/Immunology	☐ Autoimmune Disease ☐ Seasonal Allergies ☐ Negative	
Cardiovascular	☐ Chest Pain ☐ Shortness of Breath ☐ Swelling of Feet ☐ Racing Pulse ☐ Irregular heart beat	☐ Blood Pressure Stable ☐ Blood Pressure Uncontrolled ☐ Blood Pressure Unknown ☐ Unspecified ☐ Negative

Constitutional	☐ Fever	☐ Chills
	☐ Weight Loss	☐ Unexplained weight loss
	☐ Fatigue	☐ Night Sweats
	☐ Loss of Appetite/Feels Sick	☐ Negative
Endocrine	☐ Excess Thirst	☐ Dry Skin
	☐ Heat Intolerance	☐ Blood Sugars Stable
	☐ Cold Intolerance	☐ Poor Blood Sugar Control
	☐ Hair Loss	☐ Negative
Gastrointestinal	☐ Abdominal Pain	☐ Constipation
	☐ Nausea	☐ Trouble Swallowing
	☐ Diarrhea	☐ Jaundice or Yellow Skin
	☐ Stomach Ulcers/Bloody Stool	☐ Negative
Genitourinary	☐ Pain/Burning on Urination	☐ Kidney Stones
	☐ Blood in Urine	☐ Kidney Problems
	☐ Bladder Trouble	☐ Prostatitis
	☐ Dialysis	☐ Testicular Pain
	☐ Genital Sores or Ulcers	☐ Urinary Discharge
	☐ Kidney Failure	☐ Negative
Hematology/Oncology	☐ Easy Bruising	☐ Unspecified
	☐ Prolonged Bleeding	☐ Negative
Hent	☐ Hearing Loss	☐ Jaw Claudication
	☐ Sore Throat	☐ Ear Ache
	☐ Runny Nose	☐ Unspecified
	☐ Dry Mouth	☐ Negative
Integumentary	☐ Rash	☐ Severe Itching
	☐ Skin Sores	☐ Unspecified
	☐ Skin Cancer	☐ Negative
Musculoskeletal	☐ Muscles Aches	☐ Back Pain while sleeping/awakening
	☐ Joint Pain	☐ Unspecified
	☐ Difficulty lying flat	☐ Negative
Neurologic	☐ Weakness	☐ Stroke
	☐ Headaches	☐ Numbness/Tingling in Body
	☐ Scalp Tenderness	☐ Seizures/Convulsions
	☐ Dizziness	☐ Fainting
	☐ Paralysis of Extremities	☐ Unspecified
	☐ Tremor	☐ Negative
Psychiatric	☐ ADHD	☐ Depression/Anxiety
	☐ Bipolar Disorder	☐ Negative
Respiratory	☐ Wheezing/Cough	☐ Difficulty Breathing
	☐ Severe/Frequent Colds	☐ Negative