TAYLOR RETINA CENTER, P.A.

PATIENT INFORMATION FORM
PLEASE PRINT CLEARLY

Patient Name:_____ **Male**_____ **Female**_____

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

Race: (check one) ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or other Pacific Island ☐ Other ☐ Decline

Ethnicity: (check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Preferred Language: English Spanish **Other:**_____

Patient Address:_____

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

Home Phone:_____ **Cell Phone:**_____

Employer Name:_____

Employer Address:_____
Number Street

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

Spouse's Name:_____ **Spouse's Work Number:**_____

Spouse's Birth Date:_____

EMERGENCY CONTACT (Someone not living with you)

Name:_____ **Relationship:**_____

Home Phone:_____ **Work Phone:**_____

INSURANCE INFORMATION

Please have your insurance cards ready for us to copy

Primary Insurance Co. Name:_____

Subscriber's Name:_____ **DOB:**_____

Policy Number:_____ **Group #:**_____

Secondary Insurance Co. Name:_____

Subscriber's Name:_____ **DOB:**_____

Policy Number:_____ **Group #:**_____

- - PLEASE COMPLETE AUTHORIZATION FORM ON BACK - -

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare or Commercial insurance by phone, mail or fax. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignments. I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatment. (Section 1128 B of the Social Security Act and 12 U. S. C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply. This authorization is in effect until I choose to revoke it.

I understand that if my insurance denies payment or if I have no insurance coverage, that I am financially responsible.

DATE:_____ **SIGNED:**_____

(Patient or Legal Guardian)

PRIMARY INSURANCE **SECONDARY INSURANCE**

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy/read a copy of the Notices of Privacy Practice for the Taylor Retina Center.

Signature:_____ Date:_____

For Office Use Only:

We were unable to obtain a written acknowledgment of receipt of the Notice of Privacy Practices because:

❑ An emergency existed & a signature was not possible at the time.

❑ The individual refused to sign.

❑ A copy was mailed with a request for a signature by return mail.

❑ Unable to communicate with the patient for the following reason:_____

Prepared by:_____ Signature:_____ Date:_____

Taylor Retina Center

MEDICAL HISTORY QUESTIONNAIRE

Adapted from the American Academy of Ophthalmology

Name:_____ DOB:_____ Date:_____

MEDICAL/SURGICAL HISTORY and REVIEW OF SYSTEMS

	YES	NO	EXPLANATION OF PROBLEM
Eyes	[ ]	[ ]	_____
Blurry or Distorted Vision	[ ]	[ ]	_____
Shadow in Vision	[ ]	[ ]	_____
Sensitivity to Light	[ ]	[ ]	_____
Eye Pain	[ ]	[ ]	_____
Eye Redness	[ ]	[ ]	_____
Amsler Grid Changes	[ ]	[ ]	_____
Flashes or Floaters	[ ]	[ ]	_____
Heart Disease (heart attack, afib)	[ ]	[ ]	_____
Brain Disease (stroke, seizures, migraine)	[ ]	[ ]	_____
Kidney Disease (dialysis)	[ ]	[ ]	_____
Blood Vessel (hypertension, carotid)	[ ]	[ ]	_____
Lung Disease (COPD, asthma)	[ ]	[ ]	_____
GI Disease (stomach, intestines)	[ ]	[ ]	_____
Musculoskeletal (muscles, joints)	[ ]	[ ]	_____
Psychiatric (depression, anxiety)	[ ]	[ ]	_____
Endocrine (diabetes, A1C, type 1 or 2?)	[ ]	[ ]	_____
Blood Disorders (sickle cell, leukemia)	[ ]	[ ]	_____
Cancer (lung, breast, colon, etc)	[ ]	[ ]	_____
Infectious Disease (TB, Hep C, HIV)	[ ]	[ ]	_____
Other medical disease not listed above?	[ ]	[ ]	_____
Have you had any surgery in the past?	[ ]	[ ]	If so, please list the type and date below:

_____

_____

_____

FAMILY AND SOCIAL HISTORY

	YES	NO	PLEASE EXPLAIN
Any family member with eye disease?	[ ]	[ ]	_____
(ie: glaucoma, macular degeneration)			_____
Do you drink alcohol? # per week?	[ ]	[ ]	_____
Do you smoke? # packs per day?	[ ]	[ ]	_____
List current or prior occupation			_____
Are you currently single, married, or widowed?			_____

Taylor Retina Center

Jeffrey Taylor, MD Nitin Gupta, MD J Carey Pate, MD

MEDICAL HISTORY QUESTIONNAIRE - Adapted from the American Academy of Ophthalmology

PAST HISTORY (EYE)

	YES	NO	EXPLANATION OF PROBLEM
Macular Degeneration (dry or wet?)	[ ]	[ ]	_____
Diabetic Retinopathy (previous laser?)	[ ]	[ ]	_____
Retinal Detachment (where? when?)	[ ]	[ ]	_____
Cataracts (surgery? If so when?)	[ ]	[ ]	_____
Glaucoma (drops? surgery? laser?)	[ ]	[ ]	_____
Retina Surgery (where? when?)	[ ]	[ ]	_____
Other eye disease, surgery, laser?	[ ]	[ ]	_____

MEDICATIONS

	YES	NO	EXPLANATION OF PROBLEM
Do you have any medication allergies?	[ ]	[ ]	Sulfa? Penicillin? Iodine?
			_____
Are you currently taking blood thinners?	[ ]	[ ]	Aspirin? Plavix? Coumadin?
			_____

Please list all medications you currently take: (include reason for taking)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Sign:_____ DOB:_____ Date:_____ _____MD

DO NOT WRITE BELOW THIS LINE

Medication Update: _____ _____ _____ _____ _____ _____

EYE DIAGNOSIS AND PROCEDURE LIST:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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