Salt Lake Retina

PATIENT INFORMATION

PLEASE **PRINT CLEARLY** AND COMPLETE ENTIRE FORM

Name _____
FIRST MIDDLE INITIAL LAST SUFFIX (Jr., etc.)

Address _____
STREET CITY STATE ZIP

SS# _____ Sex M F Birthdate_____ Age____

Occupation _____ Employer _____

Home phone ( ) _____ Cell phone ( ) _____

Marital Status S M D W Business phone ( ) _____Ext_____

CHECK ONE: □ Medicare/Medicaid/Insurance □ Workman's Comp □ Self-pay/no insurance

RESPONSIBLE PARTY (parent or guardian)

IF SAME AS PATIENT, THEN LEAVE THIS BLANK

Name _____
FIRST MIDDLE INITIAL LAST SUFFIX (Jr., etc.)

Relationship to Patient _____

Address _____
STREET CITY STATE ZIP

SS# _____ Sex M F Birthdate_____ Age____

Occupation _____ Employer _____

Home phone ( ) _____ Business phone ( ) _____Ext_____

INSURANCE INFORMATION (skip this section if a copy of your insurance card is on file)

Primary Company _____ Address _____

Policy Number _____ Group # _____ Phone _____

Insured _____ Relationship to Insured _____

Employer _____ Date of Birth _____

Secondary Company _____ Address _____

Policy Number _____ Group # _____ Phone _____

Insured _____ Relationship to Insured _____

Employer _____ Date of Birth _____

EMERGENCY CONTACT INFORMATION

Emergency Contact _____ Relationship _____ Phone _____

Patient Medical History

Name: _____ **DOB**: _____ **Date**: _____

Who may we thank for your referral? _____

What is the reason for your visit today (major problem)? _____
Which eye? □ Right □ Left □ Both
What are your other symptoms? □ pain □ flashes □ floaters □ curtain □ blurry vision, other: _____
How long have you had this? #___ days ___ weeks ___ months ___ years other: _____

Allergies: □ none _____

Current medications: □ none _____
_____

Vitamins/supplements: □ none _____

Who is your regular/general doctor? _____Phone: _____

Eye problems:□ cataract □ glaucoma
□ macular degeneration (AMD) □ diabetic retinopathy
□ blocked blood vessels (vein or artery) □ dry eye
□ retinal detachment □ other _____

Medical problems: □ high blood pressure □ cancer (type) _____
□ stroke □ diabetes # _____ years □ arthritis
□ anemia □ high cholesterol □ asthma □ depression
□ seasonal allergies □ thyroid □ low □ high □ blood clots □ anxiety
□ gout □ heart disease □ low □ high heart rate
□ emphysema □ HIV □ AIDS □ hepatitis □ other: _____

Do you smoke? □ yes □ no # packs a day? _____ Do you drink alcohol? □ yes □ no
Do you use street drugs? □ yes □ no Type? _____ Are you pregnant? □ yes □ no

Past eye surgeries: □ cataract surgery □ right □ left □ retina surgery □ rt □ left
□ glaucoma surgery □ right □ left □ LASIK □ right □ left

Past surgeries: □ none _____

Family history (please indicate relation to you in blanks):
□ eye problems □ early cataract □ glaucoma □ retinal detachment □ other _____
□ high blood pressure □ diabetes □ arthritis
□ high cholesterol □ asthma □ thyroid □ low □ high
□ blood clots □ heart disease □ low/high heart rate
□ cancer (type) _____ □ other: _____

(please complete back side)

3855 West 7800 South #100 *4155 West 3465 South #4*
West Jordan, Utah 84088-5561 801-260-0034 office • 801-260-0035 fax West Valley City, Utah 84120

Patient Medical History

Review of Systems

Please mark all that you are **currently** experiencing.

General:
□ weight loss/gain
□ recent cold/flu
□ inability to exercise
□ other: _____

Head/Ears/Nose/Throat:
□ headaches
□ colds
□ flu
□ difficulty swallowing
□ hearing problems
□ other: _____

(**Female**):
□ pregnant
□ post-menopausal
□ hormone-replacement therapy
□ oral contraceptives
□ other: _____

Breast:
□ lumps
□ tenderness
□ discharge
□ swelling
□ other: _____

Heart:
□ chest pain
□ heart murmurs
□ irregular heartbeat
□ other: _____

Lungs:
□ asthma
□ difficulty breathing
□ cough
□ fever
□ night sweats
□ other: _____

Genitals/Urinary:
□ increased urination
□ difficulty with urination
□ kidney stones
□ incontinence
□ venereal disease
□ other: _____

Skin:
□ rash
□ itching
□ inc. pigmentation
□ changes in hair growth or loss
□ nail changes
□ other: _____

Gastrointestinal:
□ abdominal pain
□ jaundice
□ constipation
□ nausea/ vomiting
□ diarrhea
□ other: _____

Muscles/Skeleton:
□ pain
□ swelling
□ redness or heat of muscles or joints
□ limitation of motion
□ muscular weakness
□ other: _____

Neurologic/Psychiatric:
□ migraines
□ tremors
□ memory loss
□ anxiety
□ depression
□ strokes
□ numbness
□ tingling
□ other: _____

Allergic/Immunologic/ Endocrine:
□ skin rashes
□ hormone therapy
□ increased thirst
□ increased urination
□ heat/cold intolerance
□ other: _____

Blood:
□ anemia
□ bleeding tendency
□ blood clots
□ previous transfusions or reactions
□ other: _____

Other problems:
□ other: _____

□ **none of the above**

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SALT LAKE RETINA

PATIENT CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby consent to Salt Lake Retina using or disclosing my protected health information for the purposes of providing treatment to me, obtaining payment for health care services rendered to me, and to carry out the Practice's health care operations.

I understand that the Practice may condition its diagnosis or treatment of me upon my consent to allow its use or disclosure of my protected health information.

I acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provided a more detailed description of the uses and disclosures allowed by this consent. I acknowledge my right to review the Notice of Privacy Practices prior to signing this consent. The Practice reserves the right to change the privacy practices outlined in the Notice of Privacy. I may obtain a revised copy by contacting the **Privacy Officer** at **801-260-0034** or writing to **Salt Lake Retina, 3855 W 7800 S, Suite 100, West Jordan, UT 84088.**

I understand that I have the right to request how the Practice uses and discloses my protected health information for treatment, payment or the health care operations. The Practice is not required to agree to any restriction, but if it does, the restriction is binding on the Practice.

I have the right to revoke this consent in writing, except to the extent that the Practice has taken action in reliance on this consent.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority