Welcome to Annan Retina Eye Center. We appreciate the opportunity of providing your eye care. Please complete the following information for our records. Thank You.

Registration Form

Today's date: __________
□ Mr. □ Mrs. □ Ms. □ Dr. Name ____
Mailing Address:____

City: ______________________ **State:** _______________________ **Zip Code:**_________

Phone: (   ) ___________________________ **Work: (   )**_____________________________

Mobile: (   )_______________________________ **Fax: (   )**___________________________

Date of birth: ________________________ **SS#**________________________________

Email Address: ________________________ **Occupation:** _______________________

Race: □ White □ Black/African American □ Asian/ Pacific Islander □ Latino/ Hispanic origin □ American Indian/ Alaskan Native □ Other _______________________________

Preferred Language: ___________ **Marital Status: Married/Single/Divorced/Separated/Widowed**

Referred By: _________________________ **Phone:** ______________________________

Referring doctor's address: ____

PRIMARY MEDICAL DOCTOR NAME: ____

PRIMARY MEDICAL DOCTOR PHONE: ____

Medical Doctor Address: ____

Emergency contact #1: ___________________________ **Phone:** ____________________

Emergency contact #2: ___________________________ **Phone:** ____________________

Medical insurance (Primary and secondary) : ___________________________________

***Policy holder name and date of birth:** ____

Policy No. : ______________________________ **Group No. :** _______________________

***Pharmacy Name:** _________________________ **Street:** ___________________________
Phone: __________________________________ **City:** ______________________________

If Patient is a minor/dependent:
Name of responsible party: ________________________ **Relationship:**_______________
Responsible party address:________________________ **Date of birth:** _______________
City: __________________**State:** ____________**Zip code:** __________ **Phone:**___________

THERE IS A $250 DEPOSIT DUE AT CHECK-IN FOR NON-INSURED PATIENTS : (please circle)

CASH   CREDIT CARD

Patient History Questionnaire

Name : **Date :**

Please state reason for visit:

Previous eye conditions and surgeries: _____ **None**

List ALL Medical Conditions: _____ **None**

____ Diabetes ______ years ____ High Blood Pressure ____ Heart Disease ____ HIV/AIDS
____ Kidney Dialysis/Disease ____ Bleeding Disorder ____ Cancer ____ Thyroid Disease
____ Lung Disease ____ Vascular Disease ____ Stroke ____ High Cholesterol

List Other Medical Problems and Major Surgeries: _____ **None**

List ALL Current Medications (include non-prescription drugs): _____ **No medications**

Allergies and Drug Reactions: ______ **No known drug allergies**

Social History: Circle answer
Do you drink alcohol? No Yes (if yes, how often?) ________________________________

Do you currently smoke, chew, or use cigars?
No Yes (if yes, how often?) ___________________________________
If you no longer smoke, when did you quit? _____________________________________

Do you abuse drugs? No Yes (if yes, explain) ________________________________
Do you drive? No Yes
Do you live alone? No Yes
Do you reside in a skilled nursing facility / assisted living? No Yes
Have you ever had a blood transfusion? No Yes

Family History:
Any relative with: ____Glaucoma____
____ Macular Degeneration? __________________________________
____ Other? ____

Patient History Questionnaire

Name:	Date:

Review of Systems:
If you are currently having any problems in the following areas, please circle and explain.

CONSTITUTIONAL: fever, weight loss, fatigue, trouble standing from chair ☐ none

SKIN: itching, rash, infection, ulcer, tumors (growths), other: ☐ none

LYMPHATIC: swelling or tenderness of lymph nodes, other: ☐ none

MUSCULOSKELETAL: muscle pain, cramps, joint pain, swelling, other: ☐ none

ENDOCRINE: confusion, fainting, nervousness, hot/cold intolerance, hair loss ☐ none

ALLERGY/IMMUNOLOGY: recurrent infections, hay fever, hives, food/drug allergy ☐ none

HEAD: headaches, dizziness, vertigo, other ☐ none

EARS: hearing loss, ringing, infections, other ☐ none
NOSE: bleeding, loss of smell, congestion, sinus problems, other
THROAT: dry mouth, loss of taste, difficulty swallowing, hoarseness, other

NECK: pain, swelling, stiffness, other: ☐ none

BREAST: tenderness, swelling, lumps, discharge, other: ☐ none

HEMATOLOGIC: fever/chills; bruise easily, prolonged bleeding, skin hemorrhages ☐ none

RESPIRATORY: wheezing, cough, difficulty breathing, asthma, other: ☐ none

CARDIOVASCULAR: (heart/ blood vessels): chest pain, swelling of extremities, ☐ none
shortness of breath, exercise intolerance, other

GASTROINTESTINAL: (stomach/intestines): nausea, vomiting, constipation, ☐ none
diarrhea, pain/cramps, bleeding, other

GENITOURINARY: (genitals/kidney/bladder): frequency, burning, ☐ none
pain or bleeding on urination, infections, incontinence, other

NEUROLOGIC: weakness in arms or leg, numbness, or tingling, ☐ none
loss of consciousness, falls, difficulty walking, seizures, tremors, neuralgia, other

PSYCHIATRIC: disorientation, mood swings, anxiety, depression, hallucinations ☐ none

This form completed by: Patient Family Staff

Acknowledgement of Review of
Notice of Privacy Practices

As the law requires, neither your physician nor any member of his staff are permitted to give or discuss any information, whether written or oral, regarding your condition or treatment to any third party (relative, friend, co-worker, employer, insurance company, etc.) without your express written authorization. However, a letter of consultation of your condition will be sent to the referring physician and your primary care doctor.
I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____
Signature of Patient or Personal Representative

____
Date

Are there other family members or persons with whom you authorize us to discuss your medical information? □ Yes □ No If yes:
Name: ____
Phone: ____
Relationship: ____
Name: ____
Phone:____
Relationship: ____