Retina Associates of Orange County
Patient Registration Form

Patient Information

Name:_____ Birthdate:_____

Address:_____City: _____State:_____Zip:_____

Home Phone:_____ Cell Phone:_____ ☐ OK to leave a detailed message

Race:_____ Language: _____ Sex:_____

Marital Status: Married / Divorced / Widowed / Single

Referring Eye Doctor:_____ Phone # _____ Fax # _____

Primary Care Physician:_____ Phone # _____ Fax # _____

Emergency Contact:_____ Phone Number:_____

Your Pharmacy Name: _____ Cross Streets: _____

Insurance Information

Primary Insurance:_____ Secondary Insurance:_____

Name of Insured:_____ Birthdate:_____

Relation to Patient:_____

☐ I am an established patient and I acknowledge that my medical insurance has not changed since my last visit.

Financial Responsibility

Please Read and Sign Below

I hereby authorize the physicians and staff of Retina Associates of Orange County to perform procedures necessary to diagnose and treat my condition properly and such treatments as may be prescribed by my attending physician during any and all visits to Retina Associates of Orange County. I understand that I am financially responsible for all charges for services rendered to me by Retina Associates of Orange County. Also, I acknowledge that the information I provided above is true and accurate.

Name: _____

Relationship to Patient: _____

Signature : _____ Date:_____

RETINA ASSOCIATES OF ORANGE COUNTY

John S. Lean, M.D. Desmond E. McGuire, M.D. Charles W.G. Eifrig, M.D. John C. Hwang, M.D. Mrinali Gupta, M.D.

Diseases and Surgery of the Retina, Macula and Vitreous

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize doctors at ***Retina Associates of Orange County*** and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

This consent is valid for 1 year or until revoked by me in writing.

_____ _____

Patient (Signature) Date

2010 East First Street, Suite 140, Santa Ana, CA 92705 Phone: (714) 543-6020 Fax: (714) 543-1720
23521 Paseo de Valencia, Suite 207, Laguna Hills, CA 92653 Phone (949) 707-5125 Fax: (949) 707-5129
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Notice of Privacy Practices

It is our desire to communicate to you the new Federal Laws (HIPAA-Health Portability and Accountability Act) written to protect the confidentiality of your health information. We do not ever want to delay treatment because you are afraid your personal health history might be unnecessarily made available to other outside of our office.

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information.

This has challenged us to review not only how your health information is used within our computers, but also with the internet, phone faxes, copy machine and charts. In accordance, we have developed policies and procedures which make sure your health information will be used only for the purposes of providing your treatment, obtaining payment and conducting health care operations.

To Provide Treatment:
We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures to schedule and coordinate care between physician, technician, back office assistants, and business office staff.

In addition, we may share your health information with referring physicians, primary care physicians, clinical and pathology laboratories, pharmacies or health care facilities and personnel providing your treatment.

To Obtain Payment:
Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automotive insurer, or workers compensation. For example, your health plan may request and receive information on dates of service, the services provided, and the medial condition being treated.

Appointment Reminders and Caregivers:
Your health information will be used by our staff to send you appointment reminders, missed appointments or to reschedule your appointment. These communications may include postcards, letters or telephone reminders. We may share you health information with those you tell us will be helping you with your home treatment, medications or payments.

Other Uses and Disclosures Require Your Authorization:
Disclosure of your health information or its use for any purpose other that those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization.
However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Signature : _____ Print Name: _____

Patient Name:_____ **D.O.B:_____**

Patient Medical History:

(Please check the following conditions that apply to you and circle or specify the appropriate choice when given)

____AIDS/HIV
____Allergies (Chronic or Seasonal)
____Alzheimers
____Anemia (Sickle Cell or Other)
____Angina Pectoris
____Arthritis
____Asthma
____Atrial Fibrillation
____Autism
____Autoimmune Disease
____Bell's Palsy
____Benign Neoplasm of Skin
____Blood Clots (Phlebitis)
____Cancer (Specify:_____
____COPD
____Congestive Heart Failure
____Coronary Artery Disease
____Dementia
____Diabetes Mellitus (Type 1 or Type 2?)
Year Diagnosed: _____
____Diverticultis
____Down Syndrome
____Enlarged Prostate
____GERD
____Gout
____Headache/Migraine
____Hepatitis (A, B, or C?)
____Hernia
____High Blood Pressure
____High Cholesterol
____Chronic Heart Disease
____Kidney Dialysis
____Kidney Disease/Stones
____Liver Disease
____Multiple Sclerosis
____Myocardial Infarction (Heart Attack)
____Neuropathy
____Obesity
____Osteoporosis
____Parkinson's Disease
____Peptic Ulcer Disease
____Pneumonia
____Psychiatric (Depression, Anxiety, etc.)
Specify: _____
____Radiation Treatments
____Seizures/Epilepsy
____Stomach Ulcer
____Stroke
____Thyroid Disease (High or Low?)
____Tuberculosis (TB)
____Other (Specify:_____

Have you received the pneumonia vaccination? Yes No (Year:_____)
Have you received the flu shot for this year? Yes No

Surgery History:

____Amputation
____Angioplasty
____Appendectomy
____Back Surgery
____Brain Surgery
____Bladder Surgery
____Blood Transfusion
____C-Section
____Carotid Endarterectomy
____Carpal Tunnel
____Colon Resection
____Cancer:_____
____Dialysis Surgery
____Gall Bladder
____Gastric Bypass
____Heart Bypass
____Heart Stent
____Hernia Surgery
____Hemorrhoidectomy
____Hip Surgery
____Hysterectomy
____Knee Surgery
____Neck Surgery
____Lumpectomy
____Masectomy (Lt or Rt)
____Pacemaker
____Shoulder Surgery
____Thyroidectomy
____Tonsillectomy
____Transplant:_____
____Tubal Ligation
____Vasectomy
____Other: (Specify:_____

Family Medical History (Please circle all that apply):

Macular Degeneration	Y / N Relation:_____	Diabetes	Y / N Relation:_____
Retinal Detachment	Y / N Relation:_____	Cancer	Y / N Relation:_____
Glaucoma	Y / N Relation:_____	Heart Disease	Y / N Relation:_____

Current Medications, Eye Drops, and/or Vitamins:

_____
_____
_____
_____
_____

Please list any allergies to medications and/or eyedrops with your reactions:_____

Social History (Please circle the following):

Tobacco Use?	Never	Previously but Quit	Yes Packs/Day____
Alcohol Use?	Never	Previously but Quit	Yes Frequency_____
Substance Abuse?	Never	Previously but Quit	Yes Type_____

*** What is the reason you were referred to the retina specialist today? _____**