# RETINA ASSOCIATES OF ORANGE COUNTY

## Patient Registration Form

## Patient Information

Name:______________________________________________ Birthdate:__________________

☐ ***I'm an established patient. I acknowledge that my personal information has not changed since my last visit.***

Address:________________________________City: __________________State:______Zip:__________

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

Email:______________________________________ Language: _______________ Sex:___________

Marital Status: Married / Divorced / Widowed / Single Race: ______________________________

Referring Eye Doctor:___________________________ Phone # __________________ Fax # ________________

Primary Care Physician:_________________________ Phone # __________________ Fax # ________________

Emergency Contact:______________________________________ Phone Number:_________________________

Your Pharmacy Name: ___________________________________ Cross Streets: ___________________________

## Insurance Information

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

Primary Insurance:______________________________ Secondary Insurance:______________________________

Name of Insured:______________________________________________________ Birthdate:__________________

Relation to Patient:________________________________

## 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:_______________________________**

**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:________ |
| Retinal Detachment | Y / N | Relation:________ |
| Glaucoma | Y / N | Relation:________ |
| Diabetes | Y / N | Relation:________ |
| Cancer | 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? _______________**