MARYLAND RETINA INSTITUTE

Please note, there are extra pages at the end for any information that does not fit for you.

Plese email completed forms to marylandretinainstitute@gmail.com

Today's date: _____

Patient Information			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Cell Phone	Home Phone	Work Phone	Email Address
Other Name(s) Used			
Gender ☐ M ☐ F	SSN		

Marital Status	**Preferred Contact**	**Ethnicity**	**Race**
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner	**Which form of communication do you approve for us to contact you?** ☐ Home Phone ☐ Work Phone ☐ Cell Phone	☐ Hispanic/Latino ☐ Non-Hispanic ☐ Unknown/or decline to answer	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other (decline to answer)
PCP Address	Referring Doctor Address	Cardiologist Address	Endocrinologist Address

Responsible Party (Guarantor)		**If same as patient, check here ☐ and SKIP SECTION**	
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Cell Phone	Home Phone	Work Phone	
SSN	Relationship to Patient	Driver's License	

Emergency Contact (for minor child, this section may be used for other parent)			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Cell Phone	Home Phone	Work Phone	

Insurance information (Please complete all details)			
Primary insurance	ID # and Group #	DOB	Subscriber and relationship
Secondary insurance	ID # and Group #	DOB	Subscriber and relationship

I/We do hereby consent to and authorize the performance of all medical services and treatments deemed advisable by the physicians and staff of Maryland Retina Institute (MRI) to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained herein are true. I understand that, although the providers of MRI may or may not participate with my insurance carrier(s), I am financially responsible for any co-payments, deductibles, and payment for non-covered services or out of network services incurred for myself and/or my dependent(s). I furthermore agree to pay accrued interest, if applicable, collection expenses, and reasonable attorneys' fees incurred to collect any amount I may owe. I also hereby authorize MRI to release information as necessary for and/or requested by the insurance company and/or its representatives for claims processing and payment. I fully understand this agreement and consent will continue until cancelled by me in writing.

Signature of Patient/Responsible Party	Date
Name of Patient/Responsible Party (Please Print)	Relationship to Patient

Name: _____ DOB: _____

Pharmacy Information	
Preferred Pharmacy	**Secondary Pharmacy**
Name	Name
Address	Address
Phone	Phone
Fax	Fax

Advanced Directives

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ HC Proxy

Date Reviewed:

Medications – List all medications you take, prescription and non-prescription, and the dosage

☐ **I do not take any medications**

Medication Name	Dosage/strength

Medication and Food Allergies – List all known allergies (drugs, food, animals, etc.)

☐ No Known Allergies

Family History – Check if any family member(s) has had any of the following conditions.

☐ Adopted

Diagnosis	Mother	Father	Brother	Sister	Other	Relationship
Anemia	☐	☐	☐	☐	☐	
Arthritis	☐	☐	☐	☐	☐	
Blindness	☐	☐	☐	☐	☐	
Cancer (type)	☐	☐	☐	☐	☐	
Cataract	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	
Diabetic Retinopathy	☐	☐	☐	☐	☐	
Glaucoma	☐	☐	☐	☐	☐	
Heart Disease	☐	☐	☐	☐	☐	
Hepatitis	☐	☐	☐	☐	☐	
Hypertension	☐	☐	☐	☐	☐	
Kidney Disease	☐	☐	☐	☐	☐	
Macular Degeneration	☐	☐	☐	☐	☐	
Retinal Detachment	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	☐	
Thyroid Disease	☐	☐	☐	☐	☐	
Uveitis	☐	☐	☐	☐	☐	

Name: _____ DOB: _____

Medical History – Check if you have ever experienced the following conditions, and year of onset.			
Condition	**Year**	**Condition**	**Year**
☐ None		☐ Marfan's Syndrome	
☐ Alzheimers		☐ Migraines	
☐ Anemia		☐ Mitral Valve Prolapse	
☐ Arthritis		☐ Multiple Sclerosis	
☐ Asthma		☐ Myasthenia Gravis	
☐ Blood Clots		☐ Neurofibromatosis	
☐ Bronchitis		☐ Osteoporosis	
☐ Cancer – Type		☐ Psychosis	
☐ Cardiovascular Disease		☐ Sarcoidosis	
☐ Depression		☐ Schizophrenia	
☐ Diabetes (**see questions below**)		☐ Seizure	
☐ Diverticulitis		☐ Sinusitis	
☐ Emphysema		☐ Sjogren's Syndrome	
☐ Hearing Loss		☐ Skin Cancer	
☐ Heart Attack		☐ Steroid Therapy (long term)	
☐ Heart Murmur		☐ Stevens-Johnson Syndrome	
☐ Hepatitis		☐ Stickler Syndrome	
☐ HIV		☐ Stroke	
☐ Hypercholesterolemia		☐ Thyroid condition	
☐ Hypertension		☐ Temporal Arteritis	
☐ Irregular Heart Beat		☐ Tuberculosis	
☐ Juvenile Rheumatoid Arthritis		☐ Ulcers	
☐ Keloid scarring		☐ Urinary Infections	
☐ Kidney Infections		☐ Von Hippel-Lindau Syndrome	
☐ Lupus		☐ Other	
☐ Lyme Disease			
☐ Mania/Bipolar			

Diabetes

Diabetes/when diagnosed? _____ Are you on insulin? ☐ Yes ☐ No X per day _____

What is Hgb A1C? _____ Recent Range: From _____ to _____ Do you test at home? ☐ Yes ☐ No

Are you on dialysis? ☐ Yes ☐ No

Name: _____ DOB: _____

Please list any prior eye problems & treatments:		
No	Glaucoma	treatment:
No	Macular Degeneration	treatment:
No	Diabetic Retinopathy	treatment:
No	Other	treatment:

Surgical History – Procedure and Year Performed.			
Non-Ocular Surgery	**Date**	**Cataract Surgery**	**Date**
		Right eye	
		Left eye	
		Type of Retinal Surgery	
		Right Eye	
		Left Eye	

Social History

Do you exercise? ☐ Yes ☐ No What kind?_____ How often?_____

Do you smoke cigarettes/cigars? ☐ Yes ☐ No Number per day:_____ Years Smoked:_____ Year quit: _____

Do you drink alcohol? ☐ Yes ☐ No How much? _____ How often?_____

Past and present drug use (legal or illegal) is important for drug and anesthetic interactions.
Please indicate if we need to be aware of this: ☐ Yes ☐ No

What is your occupation? _____ Are you still working? ☐ Yes ☐ No

Have you had a blood transfusion? ☐ Yes ☐ No When?_____

Living Conditions: ☐ With Family ☐ Nursing home ☐ Caretaker/family ☐ Alone ☐ Other_____

Do you have or have you ever had any pets? ☐ Yes ☐ No What kind?_____

Review of Systems (check all that apply)

Constitutional □ Jaw Pain □ Fever □ Weight Loss □ Fatigue □ Loss of Appetite □ Trouble Sleeping □ Other	**Cardiovascular** □ Chest Pain □ Swelling of Feet	**Endocrine** □ Excessive Thirst □ Excessive Urination □ Cold Intolerance □ Heat Intolerance □ Other	**Gastrointestinal** □ Abdominal Pain □ Nausea □ Diarrhea □ Constipation □ Other
Hent □ Hearing Loss □ Sore Throat □ Runny Nose □ Other	**Neurologic** □ Weakness □ Headaches □ Scalp Tenderness □ Dizziness □ Paralysis of Extremities □ Tremor	**Genitourinary** □ Pain/Burning with Urination □ Other	**Integumentary** □ Rash □ Change in Mole
Respiratory □ Wheezing □ Cough □ Shortness of Breath □ Other	**Hematology / Oncology** □ Easy Bruising □ Prolonged Bleeding □ Clotting Problems □ Other	**Musculoskeletal** □ Muscle Aches □ Joint Pain □ Difficulty Laying Flat from □ Muscular Discomfort	

MARYLAND RETINA
INSTITUTE

Chart #: For Office Use Only

Financial Policy Statement

Welcome to Maryland Retina Institute. We are pleased you have chosen our practice for your medical care. We are committed to providing you with the highest quality services available. We ask that you carefully read and sign the following policy. We must emphasize that, as your medical care provider, our relationship is with you and not your insurance carrier. As a courtesy to you, we will file your claim with your insurance company. However, you are the sole responsible party for all charges incurred and guarantee payment thereof. If we are contracted with your insurance company, including Medicare, we will accept assignment. You will be responsible for your payment portion at the time of service. Failure to provide necessary referrals and/ or authorizations or failure to provide current, accurate billing information will result in all charges for services becoming the sole responsibility of the patient/responsible party. You are expected to understand your benefits coverage and responsibility. This includes, obtaining any referrals and/or authorizations, which your insurance company requires before care is provided.
All co-pays, co-insurance and deductibles are due and payable at the time service is rendered. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payments at the time services are rendered.

If my account becomes assigned to collection agency, I agree to pay 36% collection fees, court costs and attorney fees. I understand that Maryland Retina Institute reserves the right at its sole discretion, to waive said requirements on a case-by-case basis.

In consideration of the services performed by Maryland Retina Institute, you agree to abide by the terms of this
Financial Statement.

Signature: _____ Date:

Patient's Authorization

I certify that the information I have provided on this form is correct. I authorize the release of any necessary information, including medical information for this or any related claim to the above named carrier(s), or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

Signature: _____ Date:

Maryland Retina Institute

Acknowledgement Notice of Privacy Practices and Consent

The Patient hereby consents to the use or disclosure of his/her individually protected health information by Maryland Retina Institute in order to carry out treatment, payment, or health care operations. The Patient should review the Facility's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosers of such information, and the Patient has the right to review such Notice prior to signing this consent form.

Facility reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If the Facility does change the terms of its Notice of Privacy Practices, we will post a summary of the current notice in our office with the effective date. You are entitles to a paper copy upon request.

Patient retains the right to request that the Facility further restrict how his/her protected health information is used or disclosed to carry out treatment, payment or health care operations. The Facility does agree to Patient's requested restriction(s), such restrictions are then binding on the Facility.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Facility in writing. The revocation shall be effective *except* to the extent that the Facility has already taken action in reliance on the Consent.

As required by law Maryland Retina Institute has provided you with Notice of Privacy Practices. This notice describes information about privacy practices followed by our health care providers, employees, staff and other office personnel. It also describes your rights and obligations in which information and records that we may have about your health, health status and the healthcare and services you receive at this office may be used or disclosed.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I AM THE PATIENT OR AM AUTHORIZED TOA CT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFIYING RECEIPT OF NOTICE OF PRIVAY PRACTICES AND CONSENT TO THE ABOVE STATED TERMS.

_____ _____

Patient Signature Please Print Name

_____ _____

Person signing on behalf of Patient Please Print Name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient: _____

_____

Maryland Retina Institute

Communication Agreement

I, _____ give the physicians of Maryland Retina Institute and their staff permission to discuss the following:

- ☐ Diagnosis, Prognosis, and /or treatment information
- ☐ Test Results
- ☐ Scheduling information
- ☐ Billing information
- ☐ Other (please specify): _____

With the following people: Example (Family, Friends, Etc) - Do Not List Doctors

_____Relationship: _____ Phone # _____

_____Relationship: _____ Phone # _____

_____Relationship: _____ Phone # _____

I also authorize the physicians of Maryland Retina Institute and their staff to:

- ☐ Leave messages on my home answering machine/voice mail
- ☐ Leave messages with my family members or others answering the phone in my home
- ☐ Leave messages on my work answering machine/voicemail

Signature:_____ Date:_____

Note: This form must be filled out completely in order for Maryland Retina Institute to ensure the privacy and confidentiality of our patients protected health information. The instructions on this form will be considered current until a new Communication Authorization supersedes them. It is the patients' responsibility to file a new form with our office if there are changes in your household situation. Maryland Retina Institute is not responsible for undesired communications resulting from the failure of a patient to file a new Communication Authorization form.

Please feel free to add any additional information here that did not fit for you above.