SALT LAKE RETINA

Patient Demographic Information

(Please print clearly and complete entire form)

General Information

Name _____ **Date of birth** _____/_____/_____ **Age** _____ **Sex** ☐M ☐F

Street address _____ **City** _____ **State** _____ **Zip** _____

SSN _____ **Marital Status** ☐Single ☐Married ☐Divorced ☐Widowed

Cell phone *required* (_____)_____-_____ **Home phone** (_____)_____-_____

Email address *required for patient reminders* _____

Preferred language _____ **Ethnicity** ☐Hispanic/Latino ***OR*** ☐Not Hispanic/Latino

Race *mark one of the below options*

☐American Indian or Alaska Native
☐Asian
☐Black or African American
☐Native Hawaiian or Pacific Islander
☐White
☐Other race
☐Decline to specify

Insurance Information

Primary Insurance

Carrier _____ Policy holder name _____

Policy number/Subscriber ID _____ Group number _____

Policy holder date of birth _____/_____/_____ Policy holder relationship to the patient _____

Secondary Insurance

Carrier _____ Policy holder name _____

Policy number/Subscriber ID _____ Group number _____

Policy holder date of birth _____/_____/_____ Policy holder relationship to the patient _____

Responsible Party (required for all patients under 18)

Name _____ Birthdate _____/_____/_____

Street address _____ City _____ State _____ Zip _____

Phone number (_____)_____-_____ Relationship to patient _____

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Patient Medical History

Name _____ **Date of birth** _____/_____/_____ **Date** _____/_____/_____

Referring Doctor _____ **Regular/Primary Care Doctor** _____

What is the reason for your visit today? _____ **Which eye is this for?** ☐Left ☐Right ☐Both

What other symptoms do you have? *(mark all that apply)*
☐Blurred vision ☐Curtain in vision ☐Double vision ☐Flashes ☐Floaters ☐Light sensitivity ☐Pain ☐Vision loss ☐Other _____

How long have you been experiencing these problems?
☐Unsure ☐1-2 days ☐3-5 days ☐1 week ☐2-3 weeks ☐1 month ☐3-5 months ☐6 months ☐1 year ☐Many years ☐Lifelong

What are your other eye problems? *(mark all that apply)*
☐AMD (macular degeneration) ☐Diabetic retinopathy ☐Retinal detachment
☐Blocked vein or artery in eye ☐Dry eye ☐Other _____
☐Cataracts ☐Glaucoma

Do you have diabetes? ☐No ☐Type 1 ☐Type 2 How many years have you had it? _____ What is your A1C level? _____

Please mark any of medical problems you have:
☐AIDS/HIV ☐Asthma ☐Gout ☐Kidney disease ☐Seizures
☐Alzheimer's ☐Cancer ☐Heart disease ☐Liver disease ☐Stroke
☐Anemia ☐Cerebral palsy ☐High cholesterol ☐Migraines ☐Thyroid disease
☐Arthritis ☐Dementia ☐Hypertension ☐Parkinson's ☐Other _____

Have you had any of the following eye surgeries? *(mark all that apply and mark the corresponding eye)*
☐Cataract surgery ☐Left ☐Right ☐Glaucoma surgery ☐Left ☐Right
☐LASIK surgery ☐Left ☐Right ☐Retina surgery ☐Left ☐Right

Please list all other past surgeries: ☐None _____

Please list all medications/eyedrops you currently use: ☐None _____

_____

Please list any medication allergies you have: ☐None _____

Family medical history (mark all that apply):
☐AMD (macular degeneration) ☐Cataract ☐Heart disease ☐Stroke
☐Amblyopia (lazy eye) ☐Coronary artery disease ☐High cholesterol ☐Thyroid disease
☐Arthritis or rheumatism ☐Diabetes ☐Hypertension ☐Uveitis
☐Blindness ☐Glaucoma ☐Kidney disease ☐Other _____
☐Cancer ☐Headaches/Migraines ☐Retinal detachment

Do you smoke? ☐Never smoker ☐Former smoker ☐Occasional smoker ☐Light smoker ☐Heavy smoker
Do you drink alcohol? ☐No ☐Occasionally/Socially ☐1-2 drinks a day ☐3-4 drinks a day
Do you use street drugs? ☐No ☐Yes (list drugs) _____
Are you pregnant? ☐No ☐Yes
Are you currently under hospice care? ☐Yes ☐No

PLEASE COMPLETE OTHER SIDE OF PAPER

Review of Systems

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

Allergy/Immunology
- ☐ Autoimmune disease
- ☐ Seasonal allergies

Cardiovascular
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Swelling of the feet
- ☐ Shortness of breath when lying flat
- ☐ Racing pulse
- ☐ Irregular heartbeat

Constitutional
- ☐ Fever
- ☐ Weight loss
- ☐ Fatigue
- ☐ Loss of appetite
- ☐ Chills
- ☐ Night sweats
- ☐ Feel sick
- ☐ Poor appetite

Endocrine
- ☐ Excess thirst
- ☐ Excessive urination
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Hair loss
- ☐ Dry skin

Gastrointestinal
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Diarrhea
- ☐ Bloody stools
- ☐ Stomach ulcers
- ☐ Constipation
- ☐ Trouble swallowing
- ☐ Gastrointestinal ulcers
- ☐ Jaundice or yellow skin

Genitourinary
- ☐ Pain/burning on urination
- ☐ Blood in urine
- ☐ Bladder trouble
- ☐ Dialysis
- ☐ Genital sores or ulcers
- ☐ Kidney failure
- ☐ Kidney problems
- ☐ Kidney stones
- ☐ Prostatitis
- ☐ Testicular pain
- ☐ Urinary discharge

Hematology/Oncology
- ☐ Easy bruising
- ☐ Prolonged bleeding

Head/Ears/Nose/Throat (HENT)
- ☐ Hearing loss
- ☐ Sore throat
- ☐ Runny nose
- ☐ Dry mouth
- ☐ Jaw claudication (pain chewing)
- ☐ Ear ache

Integumentary
- ☐ Rash
- ☐ Change in mole
- ☐ Skin sores
- ☐ Skin cancer
- ☐ Severe itching

Musculoskeletal
- ☐ Muscle aches
- ☐ Joint pain
- ☐ Difficulty lying flat
- ☐ Back pain during/after sleep

Neurological
- ☐ Weakness
- ☐ Headaches
- ☐ Scalp tenderness
- ☐ Dizziness
- ☐ Paralysis of extremities
- ☐ Tremor
- ☐ Stroke
- ☐ Numbness
- ☐ Tingling
- ☐ Seizures or convulsions
- ☐ Fainting

Psychiatric
- ☐ ADHD
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Depression

Respiratory
- ☐ Wheezing
- ☐ Cough
- ☐ Coughing up blood
- ☐ Severe or frequent colds
- ☐ Difficulty breathing

Other problems

_____

_____

_____

_____

☐ **None of the above**

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