Patient Information

Name: _____
Address: _____
_____

Home Phone#:_____ Work #:_____
Cell#: _____

Date of Birth: _____ Social Security#: _____

Male / Female Marital Status: _____

Emergency contact outside of the patient's home:
Name: _____
Phone #: _____
Relationship: _____

Doctor Information

Family Doctor/Internist: _____
Address: _____
Phone#: _____
E-mail: _____
General Ophthalmologist/Optometrist: _____
Address: _____
Phone#: _____
E-mail: _____
Other Doctors to receive reports
Name: _____
Specialty: _____
Address: _____
Phone#:_____Fax#_____
E-mail: _____

Name: _____
Specialty: _____
Address: _____
Phone#: _____Fax#_____
E-mail: _____

Insurance Information

Patient Name: _____ Date of Birth: _____

Primary Insurance: _____

Policy #: _____ Group #: _____ Copay: ____

Name of Policy Holder: _____

Relationship to policy holder: _____

Policy Holder's: Date of birth _____

Social Security # _____

Secondary Insurance: _____

Policy #: _____ Group #: _____ Copay: ____

Name of Policy Holder: _____

Relationship to policy holder: _____

Policy Holder's: Date of birth _____

Social Security # _____

Is the patient a dependent under the age of 18? Select One

If yes, please provide:

Name of person responsible for bill: _____

Address: _____

_____

Phone # _____

Relationship: _____ SS # _____

Is injury job related? Select One

If yes, please provide:

Date of accident: _____ Claim # _____

Workman's Comp Carrier: _____

Address: _____

_____

Contact name: _____ Phone #: _____

Is injury related to an auto accident? Select One

If yes, please provide:

Date of accident: _____

Name of attorney: _____

Address: _____

_____

Phone #: _____

New Patient Medical History

Patient Name: _____
Date of Birth: _____ Age: _____ Gender: Select One
Referring Ophthalmologist/Optometrist: _____
Primary Care Physician: _____
Internist/Other: _____

Chief Complaint: _____
_____
_____

Your Past Eye History

		Explanation
Past Laser Treatments for either eye?	**No Yes**	_____
Past Surgery for either eye?	**No Yes**	_____
Past Eye Injuries?	**No Yes**	_____
Other Eye Problems?	**No Yes**	_____
Do You Wear? (Circle)	**Glasses Contact Lenses**	

What do you wear your glasses for? (Circle)
Reading Only Distance Only Both or Bifocals

Your Medical History

Head (Injury, Other)	**No Yes**	_____
Ears, Nose, Throat, Mouth	**No Yes**	_____
Neck (Pain, Other)	**No Yes**	_____
Lungs, Breathing	**No Yes**	_____
Cardiovascular		
Heart Disease	**No Yes**	_____
Heart Attack	**No Yes**	_____
High Blood Pressure	**No Yes**	_____
Stomach, Intestinal	**No Yes**	_____
Liver Disease	**No Yes**	_____
Kidney, Bladder, Genital	**No Yes**	_____
Bones (Joints, Muscles, Arthritis)	**No Yes**	_____
Neurologic (Stroke, Other)	**No Yes**	_____
Bleeding Disorder (Anemia, Other)	**No Yes**	_____
Psychiatric (Depression, Other)	**No Yes**	_____
Lymphatics, Swollen Lymph Nodes	**No Yes**	_____

New Patient Medical History (Continued)

Patient Name: _____

Cancer (What type?) ○ **No** ○ **Yes _____**
Diabetes ○ **No** ○ **Yes**
If yes please provide:
Age of onset: _____
Duration: _____
Type of treatment: ○ **Pills** ○ **Insulin**
Endrocrine, other than diabetes ○ **No** ○ **Yes _____**
GYN problems ○ **No** ○ **Yes _____**
Are you pregnant? ○ **No** ○ **Yes, Due date _____**

LIST ALL PREVIOUS SURGERIES AND HOSPITALIZATIONS (DATE AND REASON):

_____
_____

FAMILY HISTORY:		**RELATIONSHIP TO PATIENT**
Blindness	○ **No** ○ **Yes**	_____
Cataract	○ **No** ○ **Yes**	_____
Glaucoma	○ **No** ○ **Yes**	_____
Macular Degeneration	○ **No** ○ **Yes**	_____
Retinal Detachment	○ **No** ○ **Yes**	_____
Diabetes	○ **No** ○ **Yes**	_____
Other	○ **No** ○ **Yes**	_____

ACTIVITIES OF DAILY LIVING (PLEASE CIRCLE)

Do you work?	○ **No**	○ **Yes**
Do you drive?	○ **No**	○ **Yes**
Can you read newsprint?	○ **No**	○ **Yes**
Do you use visual aids?	○ **No**	○ **Yes**

SOCIAL HISTORY: (PLEASE CIRCLE)
Smoke? ○ **N** ○ **Y** ○ **Q** **DURATION_____ AMOUNT_____**
Alcohol? Select One
Drug Use? Select One

Any comments? _____

Patient Medications

Patient Name: _____ Date of Birth: _____
Referring Ophthalmologist/Optometrist: _____
Primary Care Physician: _____
Internist/Other: _____

SYSTEMIC MEDICATIONS:

DATE/YEAR STARTED	TAKEN FOR MEDICAL CONDITION?	NAME OF MEDICATION	DOSAGE

ALLERGY HISTORY: **EXPLANATION**

Medication Allergies	◉ No ○ Yes	_____
Other Allergies	○ No ○ Yes	_____
Fluorescein Dye Allergy	○ No ○ Yes	_____
Iodine or Shellfish Allergy	○ No ○ Yes	_____

Elman Retina Group

Financial Agreement

The following is the Elman Retina Group Financial Policy. All patients are required to read and sign this statement acknowledging that they have been informed of this policy.

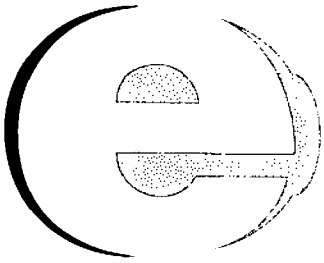
To properly submit your claim, we require that you disclose all insurance information including primary, secondary and tertiary (if applicable) coverage. Failure to provide complete and accurate insurance information may result in patient responsibility for the entire amount of the claim.

Referrals must be obtained **prior** to your visit if required by your insurance company and is the responsibility of the patient. Failure to obtain a referral may result in non-payment form your insurance company and may result in patient responsibility for the entire amount of the claim. As a courtesy for those patients requiring a referral a letter is sent as a reminder at least one week prior to your appointment.

Patients are required to pay any remaining balance in a timely manner or may be sent to collections.

By signing this statement, I agree to the terms as described above:

_____



Elman Retina Group, P.A.

Dear Patient:

We look forward to welcoming you to our practice. At the Elman Retina Group you'll receive the most expert and empathetic care possible. We are deeply committed to offering you comprehensive, state-of-the-art treatments, based on the most current scientific research and technology, in a warm and caring private office setting.

What to Expect

When you arrive at our office, you may find the reception area full of people. Please don't worry. Not all of these people are patients. Many of our patients require family or friends to accompany them. Not everyone may be there for the same type of visit and testing.

Due to the nature of the retina examination and ancillary testing, please expect to spend about two hours for a typical new patient visit. Follow-up visits generally are briefer.

At each visit, you can expect to be given dilating drops. While some people can drive after a dilated eye examination, it is best to have someone else drive you home when possible.

Please bring a list with you of prior surgeries, prescription medications you are taking, and your eye glasses.

What is a Retina Specialist?

A retina specialist is an Eye M.D. especially trained to deal with the problems affecting the delicate tissues in the back of the eye, such as the macula, retina and vitreous. The retina lines the back of the eye and "takes the picture" for the eye much like the film in a camera. The center of the retina, called the macula, is responsible for our fine central vision and allows us to read, recognize faces and thread a needle. The cavity in front of the retina and filling most of the eye contains the clear vitreous gel. Our retina specialist, Dr. Elman completed two extra years of rigorous, specialized fellowship training after finishing his ophthalmology residency. He is internationally acclaimed and uniquely qualified to diagnose and treat problems in the back of the eye, such as macular degeneration, diabetic retinopathy and retinal detachment.

Dr. Elman will evaluate and treat your retinal problems working in consultation and in partnership with your referring doctor. Your general ophthalmologist or optometrist will continue to see you for glasses and other non-retina related eye conditions. Your referring eye doctor and medical doctors will receive complete notes of each office visit to our office.