THE NATIONAL RETINA INSTITUTE
LEADERS IN THE TREATMENT OF RETINAL DISEASES

Patient Information Form

Patient Name: _____ Date of Birth: ____/____/____ Age: _____

Social Security No: _____ Home Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Sex: M F

Employer: _____ Work Phone: _____

Employer Address: _____ Occupation: _____

Spouse/Parent Name: _____ Phone No: _____

Emergency Contact Person: _____ Phone No: _____
(Someone not living with you)

Primary Insurance: _____ Policy No: _____ Group No: _____

Policy Holder: _____ Relationship: _____ Date of Birth: _____

Policyholder's Social Security No: _____

Secondary Insurance: _____ Policy No: _____ Group No: _____

Policy Holder: _____ Relationship: _____ Date of Birth: _____

Policyholder's Social Security No: _____

I hereby authorize The National Retina Institute (NRI) to bill my insurance (which may include release of medical information to process this claim). I also authorize payment to be made directly to NRI. In addition, if my account is forwarded to an outside collection agency for collection of a past due balance, I will be responsible for the collection fees incurred by NRI to said outside collection agency. ***YOUR SIGNATURE IS REQUIRED BELOW.***

Signature: _____ Date: _____

Family Physician/Internist/
Or Pediatrician: _____ Phone No: _____

Full Address: _____

Optometrist/Ophthalmologist: _____ Phone No: _____

Full Address: _____

Referring Doctor: _____ Phone No: _____

Full Address:

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Medical History Questionnaire

Name _____ **Date** _____

Date of last eye examination: _____

List all Current Medications (prescription and over-the-counter)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Do you have **ALLERGIES** to any medication? _____ YES _____ NO If YES, please list:

	Medication	**Symptoms**
1.		
2.		
3.		
4.		

Illnesses Past and Present	**YES**	**NO**	**Duration**	**Family History**	**YES**	**NO**	**Relationship**
Glaucoma				Glaucoma			
Arthritis				Arthritis			
Cancer				Cancer			
Diabetes				Diabetes			
Heart Disease				Heart Disease			
High Blood Pressure				High Blood Pressure			
Kidney Disease				Kidney Disease			
Stroke				Stroke			
Thyroid Disease				Thyroid Disease			
Asthma				Asthma			
Hay Fever or Sinus				Hay Fever or Sinus			
Emphysema				Emphysema			
Other				Other			

List any **eye surgeries** you have had (cataract, corneal transplant, etc.)

_____

_____

_____

List any **surgeries** you have had (appendectomy, tonsillectomy, etc.)

_____

_____

_____

**** PLEASE TURN OVER AND COMPLETE REVERSE SIDE ****

Rev 2011

SOCIAL

Occupation: _____

Marital Status: (circle) Married / Divorced / Single / Widowed

Do you drive?	____ YES	____ NO		____
Do you smoke?	____ YES	____ NO	If yes, how many packs per day?	____
Do you drink alcohol?	____ YES	____ NO	If yes, how many drinks per week?	____
Have you ever had a blood transfusion?	____ YES	____ NO	If yes, what year?	

Do you currently have any problems in the following areas? If **YES**, please provide information.

Review of Systems (examples)	YES	NO	Explanation of Problem
EYES (glaucoma, cataracts, blurred vision)			
GENERAL (fever, weight loss, fatigue)			
EARS, NOSE, THROAT (earaches, nose bleeds, sinus disease, sore throat)			
CARDIOVASCULAR (chest pain, palpitations)			
RESPIRATORY (cough, shortness of breath, wheezing)			
GASTROINTESTINAL (nausea, vomiting, heartburn, loss of appetite)			
GENITOURINARY (frequent urination, kidney stones, blood in urine)			
MUSCULOSKELETAL (joint pain, muscle weakness or pain)			
SKIN (rash, acne, skin cancer, warts)			
NEUROLOGICAL (headaches, paralysis, seizures)			
PSYCHIATRIC (depression, anxiety, memory loss)			
ENDOCRINE (diabetes, hypothyroid)			
HEMATOLOGIC (anemia, bleeding or bruising tendencies)			
ALLERGIC/IMMUNOLOGIC (hay fever, lupus)			

OFFICE USE ONLY:

History reviewed: _____ ***No*** _____ ***Changes as noted above***

Date: _____ ***Physician's Signature:*** _____

**** PLEASE TURN OVER AND COMPLETE REVERSE SIDE ****

THE NATIONAL RETINA INSTITUTE

LEADERS IN THE TREATMENT OF RETINAL DISEASES

THE NATIONAL RETINA INSTITUTE is pleased to announce that, effective immediately, we will begin using electronic prescriptions to manage your medications.

By utilizing this system we can automatically send your prescriptions to your pharmacy. You will no longer need to take a paper prescription to your pharmacy for non-narcotic medications.

Certain prescriptions cannot be sent electronically due to federal guidelines. In those cases, your physician will give you a paper prescription for you to take to your pharmacy.

Refill requests will also be managed in the same manner. In the future, all you will need to do is contact your pharmacy and request refills on your medication. The pharmacy will send an electronic notification to your physician to obtain approval to refill the medication.

In order to effectively send your prescriptions to the correct pharmacy, we need to collect the following information:

Patient Name: _____

Pharmacy Name: _____

Pharmacy Address: _____

_____

or Cross Street(s): _____

Pharmacy Phone Number: _____

Thank you and please let us know if you have any questions.

TOWSON • 901 Dulaney Valley Road • Suite 200 • Towson, MD 21204 • Phone: 410-337-4500 • Fax: 410-339-7326
CHEVY CHASE • 5530 Wisconsin Avenue • Suite 101 • Chevy Chase, MD 20815 • Phone: 301-986-8747 • Fax: 301-986-8944
FALLS CHURCH • 2946 Sleepy Hollow Road • Suite 1C • Falls Church, VA 22044 • Phone: 703-288-9001 • Fax: 703-288-5169
SILVER SPRING • 1400 Spring Street • Suite 101 • Silver Spring, MD 20910 • Phone: 301-562-1311 • Fax: 301-562-4019

www.nationalretina.org

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Beneficiary Name (print) _____ Medicare Number _____

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to The Bert M. Glaser National Retina Institute for services furnished me by The Bert M. Glaser National Retina Institute. I authorize any holder of medical or other information about me to release such information to Medicare so a determination of my benefits may be made. The Bert M. Glaser National Retina Institute accepts the payment determination of the Medicare carrier as payment in full from Medicare, and I am responsible only for the deductible, coinsurance and non-covered services.

2. MEDIGAP: I request that payment of authorized secondary insurance benefits be made on my behalf to The Bert M. Glaser National Retina Institute, if possible or otherwise to me. I understand and agree that I am responsible for any co-payment or deductible set by my Medigap policy. I authorize any holder of medical or other information about me to release such information to the insurer so a determination of my Medigap benefits may be made.

3. RELEASE OF INFORMATION: The Bert M. Glaser National Retina Institute may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to The Bert M. Glaser National Retina Institute for reimbursement for services rendered, and (2) any health care provider for continued patient care. The Bert M. Glaser National Retina Institute may also disclose any information considered to be de-identified under the HIPAA Privacy Standards, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data.

4. OTHER INSURANCE: I understand that The Bert M. Glaser National Retina Institute contracts with a number of health care service plans. A list of such plans is available from the business office. The Bert M. Glaser National Retina Institute does not have a contract, expressed or implied, with any plan that does not appear on the list. I understand and agree that I am obligated to pay the full charges of all services rendered to me by The Bert M. Glaser National Retina Institute if I belong to a plan that does not appear on the above mentioned list.

5. NON-COVERED SERVICES: I understand that The Bert M. Glaser National Retina Institute contracts with health care service plans (i.e., HMOs, PPOs) that state items and services which are "covered" by the health care service plans. These health service plans will not pay for items or services that fall outside its coverage rules. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. I understand and agree that it is my responsibility to obtain necessary health care service plan authorizations. Further, I also understand and agree that I am obligated to pay the full charges of all services rendered to me by The Bert M. Glaser National Retina Institute if the services are not covered by my health plan.

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by The Bert M. Glaser National Retina Institute, I will pay my account at the time service is rendered or will make other arrangements for payment that are satisfactory to The Bert M. Glaser National Retina Institute. If, for any reason, The Bert M. Glaser National Retina Institute must send my account to an attorney for collection, I agree to pay all collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate.

_____ _____

Beneficiary Signature or Authorized Party Date

PATIENT DATA FORM

FULL NAME: _____

MARITAL STATUS: _____

ETHNICITY: (CIRCLE ONE:)
- HISPANIC OR LATINO
- NOT HISPANIC OR LATINO
- UNKNOWN / NOT REPORTED
- DECLINE TO SPECIFY

RACE:
- AMER. INDIAN OR ALASKA NATIVE
- ASIAN
- BLACK OR AFRICAN AMERICAN
- HISPANIC
- NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- WHITE
- OTHER
- DECLINE TO SPECIFY

PREFERRED LANGUAGE:
- ENGLISH
- SPANISH
- OTHER:_____
- DECLINE TO SPECIFY

E-MAIL: _____

TOBACCO USE:	**HAVE YOU EVER USED TOBACCO?**	**CIRCLE ONE:**
		YES
		NO/NEVER
		UNKNOWN
IF YES, WHAT KIND OF TOBACCO:	Cigarette Cigarillo Cigar Pipe Chewing Smokeless Snuff	**(Circle One)**
USAGE PER DAY:	_____	

FALLS RISK:

FALLS IN LAST YEAR:	**YES**	**NO**	**CIRCLE ONE**
# OF FALLS IN LAST YEAR:	_____		
DID INJURY RESULT?	**YES**	**NO**	**CIRCLE ONE**
INJURY DETAILS:	_____		
	_____		
	_____		
	_____		

PHARMACY:

NAME:	_____
ADDRESS:	_____
PHONE NUMBER:	_____
FAX NUMBER:	_____

DATE:_____ **INITIALS:** _____