Northern California Retina Vitreous Associates Medical Group, Inc.
Patient Registration

Patient Name: _____ SS#:_____

Address:_____

City: _____State: _____ Zip: _____

Home Phone: ( ) _____ Cell #: ( ) _____ Work #: ( ) _____

Patient Status:☐Single☐Married☐Other ____ Sex☐Male☐Female Birthdate: _____ Age _____

Primary Care/Referring M.D. _____ Phone: _____

Employer: _____ Occupation: _____

Emergency Contact: _____

Address: _____ Phone: _____

Primary Insurance Coverage: _____

Address:_____

ID#: _____ Group #: _____ Relationship to Patient:_____

Subscriber Name:_____ **Birthdate:** _____ **SS#:** _____

Secondary Insurance Coverage: _____

Address:_____

ID#:_____ Group #: _____ Relationship to Patient: _____

Subscriber Name:_____ **Birthdate:** _____ **SS#:** _____

Consent for Use and/or Disclosure of Information I hereby give consent to Northern California Retina-Vitreous Associates Medical Group, Inc., to use and disclose my protected health information for the purpose of treatment, payment and health care operations. I also understand that my insurance carrier may require an authorization from my primary care physician or general ophthalmologist in order to approve this visit for payment. I understand that I will be financially responsible for all charges incurred at the time of this visit should that authorization be denied. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent. We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by requesting it at the time of your appointment or submitting a written request to the address below. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us. You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the address at the foot of this form. You may deliver your revocation by any means you choose, but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Sign: _____ Date: _____

Patient name(please print): _____ If you are signing as the patient's representative:

I authorize the release of medical information on my behalf to those listed below:

Name: _____ Describe your relationship: _____ _____ Initial

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MEDICAL HISTORY
& REVIEW OF SYSTEMS

NAME: _____ DATE:_____

Please check all boxes that apply to you.

Endocrine Problems: ☐ None
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Other_____

Cardiovascular Problems: ☐ None
- ☐ High Blood Pressure
- ☐ Heart Attack or Chest Pain (Angina)
- ☐ Abnormal Heart Beat
- ☐ Heart Failure
- ☐ Angioplasty or Heart Surgery
- ☐ Other_____

Respiratory Problems: ☐ None
- ☐ Shortness of Breath
- ☐ Coughing
- ☐ Asthma/Emphysema/Chronic Obst. Pulm. Dz.
- ☐ Other_____

Head/Ear/Nose/Throat Problems: ☐ None
- ☐ Headaches/Tender Scalp/Jaw Pain/Stiff Neck
- ☐ Hearing Loss
- ☐ Other_____

Digestive Problems: ☐ None
- ☐ Reflux
- ☐ Constipation/Diarrhea
- ☐ Other_____

Genitourinary Problems: ☐ None
- ☐ Dialysis or Kidney Failure
- ☐ Sexually Transmitted Disease
- ☐ Other_____

Musculoskeletal Problems: ☐ None
- ☐ Osteo Arthritis or Rheumatoid Arthritis
- ☐ Migratory or Moving Joint Pains
- ☐ Lower Back Pains
- ☐ Other_____

Neurologic/Psychiatric Problems: ☐ None
- ☐ Stroke or Transient Ischemic Attacks
- ☐ Mood Disorder: Depression/Anxiety/etc.
- ☐ Other_____

Skin Problems: ☐ None
- ☐ Rashes
- ☐ Sores in Mouth or Genitals
- ☐ Other_____

Cancer: ☐ None
- ☐ Type/s: _____
- _____
- _____

Blood/Immune Problems: ☐ None
- ☐ Bleeding or Clotting Problems
- ☐ Auto-immune Disease _____
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Other_____

Constitutional Symptoms: ☐ None
- ☐ Fever
- ☐ Fatigue
- ☐ Unexpected Weight Loss or Gain

***"Family"* Eye History (Other than You):** ☐ None
- ☐ Macular Degeneration
- ☐ Retinal Tears or Detachments
- ☐ Glaucoma
- ☐ Other_____

Social History: ☐ None
- ☐ Live Alone
- ☐ Live with (relationship) _____
- ☐ Retired
- ☐ Occupation _____

Habits: ☐ None
- ☐ Tobacco use _____
- ☐ Alcohol use_____
- ☐ Street Drug use_____
- ☐ Herbal/Vitamin Supplements _____
- _____
- _____

Surgeries: ☐ None
- _____
- _____
- _____
- _____

Please bring all of your medications, supplements and eye drops or a complete list of them with you to your appointment.

_____ M.D.

Northern California Retina-Vitreous Associates

MEDICATION & ALLERGY LIST

Patient Name:_____ **DOB: _____**

Please list all **Eye Drops** you are taking:

Name	Right / Left / Both Eyes?	Frequency

Please list all **Medicines, Insulin, Blood Thinners, Vitamins, & Supplements** you are taking:

Name	Dose	Frequency

ALLERGIES

NORTHERN CALIFORNIA
RETINA VITREOUS ASSOCIATES
ESTABLISHED IN 1983

AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City / State / Zip _____

I Hereby Authorize the Disclosure of my Health Information From:

_____
Name of Person/Organization Releasing Information

_____
Address City / State / Zip

_____
Phone Number // Fax Number

To Release my Information To:

_____
Name of Person/Organization Receiving Information

_____
Address City / State / Zip

_____
Phone Number // Fax Number

INFORMATION TO BE RELEASED:

_____Complete Medical Record
_____Medical Records for Specific Dates of Service (please list) from_____ to _____
_____Other (please list) _____

This authorization remain in effect until the information has been forwarded as requested.

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X_____ X_____
Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative DATE

_____
Description of Personal Representative's Authority (attach necessary documentation)

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Date Sent: _____ By: _____ Via: _____