VITREO RETINAL SURGEONS

THOMAS G. WARD, D.O.

PATIENT INFORMATION FORM

Insurance Cards must be presented to the Front Desk

DATE: _____ REFERRED BY: _____

PATIENT NAME: _____ SS#: _____

ADDRESS (No P.O. Box): _____
CITY/STATE: _____ ZIP CODE: _____
HOME#: _____ CELL#:_____ WORK#: _____
SEX: M_____ F_____ DOB: _____ MARITAL STATUS: S M D W

EMPLOYER: _____
ADDRESS: _____
PHONE: _____

FAMILY PHYSICIAN: _____
ADDRESS: _____
PHONE: _____

(If a minor, please complete)
NAME OF RESPONSIBLE PARTY: _____
ADDRESS: _____
PHONE: _____ RELATIONSHIP: _____

PLEASE COMPLETE THE FOLLOWING QUESTIONS:

1. Is this illness/injury work related? Yes _____ No _____
2. Was this illness/injury caused by an accident? Yes _____ No _____
   Automobile accident _____Other _____
3. Do you reside in a Nursing Home/Skilled Nursing Facility? Yes _____ No _____
   If yes, Name of Facility: _____ Phone: _____

MEDICARE
LIFETIME SIGNATURE AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I permit a copy of this authorization to be used in place of the original. I request that payment of authorized benefits be made on my behalf to the physician or organization furnishing the services and that such physician or organization has my permission to submit a claim on my behalf. In addition, I give my permission for Vitreo Retinal Surgeons to release any information concerning my insurance claim and/or any medical information deemed necessary to determine these benefits for related services. I certify that I have complete authority to execute this document on my behalf or that of the patient.

Signature: _____ Date:_____

PRIVATE INSURANCE
LIFETIME SIGNATURE AUTHORIZATION

I certify that the information given by me in applying for payment of claims submitted by Vitreo Retinal Surgeons on my behalf are correct. I permit a copy of this authorization to be used in place of the original. I request that payment of authorized benefits be made payable to the physician or organization furnishing the services. Should the contract between myself and my insurance company state that all checks be made payable to me, then I hereby ***INSTRUCT AND DIRECT*** that all checks made payable to me be mailed to the address of the provider of services, whereby the physician furnishing the services has my permission to direct deposit the check. Vitreo Retinal Surgeons has my permission to release any information concerning my insurance claim and/or any medical information deemed necessary to determine these benefits for related services. I certify that I have complete authority to execute this document on my behalf or that of the patient. Furthermore, if necessary, I authorize the provider of services to initiate a complaint to the insurance commissioner on by behalf.

Signature: _____ Date:_____

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MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Date of Birth: _____ Date of Last Exam: _____

List of Medications you currently take (prescription/over the counter):

_____

_____

_____

_____

Allergies to any medications? YES or NO
If YES, what medications? _____

List Major Illnesses or Injuries (Glaucoma, Diabetes, High Blood Pressure, Heart Attack Concussion, etc.):

_____

_____

_____

_____

List Surgeries (Cataract, Tonsillectomy, Appendectomy):

_____

_____

_____

PLEASE CIRCLE RT (Right Eye) or LT (Left Eye)

RT	LT	Lazy Eye since Birth	RT	LT	Straight lines appear crooked
RT	LT	Eye Injury: type _____	RT	LT	Sandy or Gritty Feeling
RT	LT	Loss Vision	RT	LT	Blurred Vision
RT	LT	Fluctuating Vision	RT	LT	Distorted Vision (halos)
RT	LT	Loss of Side Vision	RT	LT	Double Vision
RT	LT	Dryness	RT	LT	Mucous Discharge
RT	LT	Redness	RT	LT	Itching
RT	LT	Burning	RT	LT	Foreign Body Sensation
RT	LT	Excess tearing/watering	RT	LT	Glare/Light Sensitivity
RT	LT	Eye pain or Soreness	RT	LT	Infection of Eye or Lid
RT	LT	Tired Eyes	RT	LT	Drooping Eyelid

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MEDICAL HISTORY QUESTIONNAIRE - page 2

PATIENT: _____

PLEASE CIRCLE "YES" OR "NO" AND IF YES, PLEASE ADD EXPLANATION:

YES	NO		EXPLANATION
YES	NO	Fever (weight loss)	_____
YES	NO	Sinus Infection	_____
YES	NO	Chronic Cough	_____
YES	NO	Cardiovascular (heart, vessels, etc.)	_____
YES	NO	Gastrointestinal (stomach)	_____
YES	NO	Muscles, Bones, Joints	_____
YES	NO	Skin (acne, warts, cancer, etc.)	_____
YES	NO	Neurological (Multiple Sclerosis, etc.)	_____
YES	NO	Psychiatric (anxiety, depression, etc.)	_____
YES	NO	Endocrine (Diabetes, Hypothyroid, etc.)	_____
YES	NO	Blood/Lymph (Anemia, cholesterol, etc.)	_____
YES	NO	Allergic/Immunologic (Hay Fever, Lupus, etc.)	_____
YES	NO	Respiratory (Asthma, Emphysema, etc.)	_____
YES	NO	Genital, Kidney, Bladder	_____

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MEDICAL HISTORY QUESTIONNAIRE - page 3

PATIENT: _____

FAMILY HISTORY: M = MOTHER, F = FATHER, S = SIBLING, GP = GRANDPARENT

DISEASE/RELATIONSHIP TO PATIENT:

YES NO Blindness _____
YES NO Glaucoma _____
YES NO Diabetes _____
YES NO High Blood Pressure _____
YES NO Lupus _____
YES NO Thyroid _____

YES NO Arthritis _____
YES NO Cancer _____
YES NO Heart Disease _____
YES NO Kidney Disease _____
YES NO Stroke _____
YES NO Other _____
Explain: _____

SOCIAL HISTORY

Current Occupation: _____ retired _____ other _____

Education: _____ High School _____Vocational School _____ College Degree

Marital Status: _____ Married _____ Divorced _____ Single _____ Widowed

Living Arrangements (nursing home, etc.): _____

Do you DRIVE? YES NO

Do you have visual difficulty when driving? YES NO

Do you have problems with night vision? YES NO

Do you wear contact lenses? YES NO

Do you currently wear glasses? YES NO

Do you drink alcohol? YES NO occasional 1 per day 2-3 per day 4+ per day

Do you smoke? YES NO occasional 1/2 pack per day 1 pack/day 1+ pack/day

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PLEASE COMPLETE THE FOLLOWING IN THE EVENT YOU ARE GIVEN A PRESCRIPTION. ALL PRESCRIPTIONS ARE ELECTRONICALLY TRANSMITTED FROM OUR OFFICE DIRECTLY TO THE PHARMACY OF YOUR CHOICE.

PATIENT NAME: _____ ACCT#:_____
DATE OF BIRTH: _____ SS#:_____

PHARMACY NAME: _____

PHONE: _____

ADDRESS: _____
_____