RETINA CONSULTANTS

PATIENT REGISTRATION FORM

Max R Johnson, MD
Marina Gilca, MD
Ravi Pandit, MD, MPH

PATIENT INFORMATION

Last Name:	First Name:	M.I.:

Mailing Address:	Apt #:

City:	State:	Zip:

Home Phone:	Cell Phone:	Work Phone:

Email Address:	Appointment Reminders: ☐ Text Msg ☐ Email ☐ Phone Call

Date of Birth:	Social Security #:	Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Ethnicity: ☐ Hispanic or Latino ☐ Unknown ☐ Not Hispanic or Latino ☐ Decline	Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other Race ☐ Decline

Employer:	Phone Number:

RESIDENTIAL LIVING FACILITY – We will forward your office visit notes to the nurse at your facility

Do you live at a residential facility, such as a nursing home? ☐ Yes ☐ No

If so, which facility and unit/floor do you live at?

Facility/Unit Phone Number:	Facility/Unit Fax Number:

RESPONSIBLE PARTY – If patient is a minor, please fill out parent/guardian information below. ☐ Same as Patient

Name:	Date of Birth:	Relationship to Patient:

Mailing Address:	Phone:

EMERGENCY AND HIPAA CONTACT INFORMATION

Name:		☐ **Can discuss medical & financial information**
Home Phone:	Cell Phone:	Relationship to Patient:
Name:		☐ **Can discuss medical & financial information**
Home Phone:	Cell Phone:	Relationship to Patient:
Name:		☐ **Can discuss medical & financial information**
Home Phone:	Cell Phone:	Relationship to Patient:
Name:		☐ **Can discuss medical & financial information**
Home Phone:	Cell Phone:	Relationship to Patient:

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REFERRING AND PRIMARY CARE PHYSICIANS

Which eye doctor referred you to see us?	
Doctor:	Clinic:
Who is your regular eye doctor?	
Doctor:	Clinic:
Who is your primary medical doctor?	
Doctor:	Clinic:
Have you seen any other doctors for retinal care in the past?	
Doctor:	Clinic:
Are there any other doctors participating in your care that we should share correspondence with?	
Doctor:	Clinic:
Doctor:	Clinic:

PRIMARY MEDICAL INSURANCE INFORMATION

Insurance Company:	
Policy Number:	
Are you the policy holder: ☐ Yes ☐ No	
If not, Policy Holder Name:	
Policy Holder Date of Birth:	Relationship to Patient:

SECONDARY MEDICAL INSURANCE INFORMATION

Insurance Company:	
Policy Number:	
Are you the policy holder: ☐ Yes ☐ No	
If not, Policy Holder Name:	
Policy Holder Date of Birth:	Relationship to Patient:

I understand that the Centers for Medicare and Medicaid Services and some other third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Retina Consultants, Ltd to release all medical information necessary to secure payment of benefits for the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that excessively overdue accounts will be forwarded to an outside collection agency. I acknowledge that I have been provided a copy of the Retina Consultants HIPAA Notice of Privacy Practices document. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

Signature of Patient
or Responsible Party: ____ **Date:** ______________________

RETINA CONSULTANTS

Patient Medical History Form

DATE:___________________________

NAME:____ DATE OF BIRTH:____________________________

Please complete the form below. For medications, please list the medication name only; the medication dose is not required. If you know the year of any previous surgeries, please include that information as well.

Prescription Medications:	Supplements & Vitamins:	Allergies:
________________________________	________________________________	______________________________
________________________________	________________________________	______________________________
________________________________	________________________________	______________________________
________________________________	________________________________	______________________________
________________________________	________________________________	______________________________
________________________________	________________________________	______________________________
________________________________	________________________________	______________________________
________________________________	________________________________	______________________________
________________________________	________________________________	______________________________

Recent or Past General Surgeries:	Eye Surgeries/Procedures (i.e. cataracts, injections, lasers):
____	____
____	____
____	____
____	____
____	____
____	____

Personal / Family History:

Have you or has anyone in your immediate family had any of the following problems?

Retinal Detachment:	☐ Patient	☐ Family	☐ No	Hypertension:	☐ Patient	☐ Family	☐ No
Retinal Tear:	☐ Patient	☐ Family	☐ No	Heart Disease:	☐ Patient	☐ Family	☐ No
Macular Degeneration:	☐ Patient	☐ Family	☐ No	Stroke:	☐ Patient	☐ Family	☐ No

MedPark Medical Center
4450 31st Avenue S, Suite 200
Fargo, North Dakota 58104

701-293-9829
877-503-0251 Toll Free
701-293-0111 Fax