Colorado Retina Associates, P.C.

Patient History Record

Patient Name:_____ D.O.B:_____ Date:_____

**Past Medical History**

Do you have or have you been treated for:

| | | |
|---|---|---|
| Diabetes | Y | N |
| High Blood Pressure | Y | N |
| Heart Disease (MI/irreg beat) | Y | N |
| Lung Disease (Asthma,COPD) | Y | N |
| GI/Colitis/Liver Disease | Y | N |
| Neuro Disease/Stroke | Y | N |
| Vascular Disease | Y | N |
| Arthritis | Y | N |
| Cancer | Y | N |
| Bleeding Disorder/Anemia | Y | N |
| HIV/AIDS/STD | Y | N |
| Kidney Disease/Dialysis | Y | N |
| Thyroid | Y | N |

If yes, please explain (duration, treatment, hospitalization, surgery/date):

_____

_____

_____

_____

**Systemic Medications**

Please list name, dosage, frequency:

_____

_____

_____

_____

_____

_____

_____

**Medical Allergies**

_____

_____

_____

**Past Surgical History**

Please list all past surgeries and/or injuries:

_____

_____

_____

**Eye Disease/Surgery**

Do you have or have you been treated for:

| | | |
|---|---|---|
| Retinopathy (Diabetes, High Blood) | Y | N |
| Macular Degeneration | Y | N |
| Macular Edema | Y | N |
| Macular Hole | Y | N |
| Retinal Vein Occlusion | Y | N |
| Vitreous Floaters | Y | N |
| Vitreous Hemorrhage | Y | N |
| Retinal Tear | Y | N |
| Retinal Detachment | Y | N |
| Cataract | Y | N |
| Glaucoma | Y | N |
| Infection | Y | N |
| Inflammation | Y | N |
| Strabismus/Amblyopia | Y | N |
| Dry Eyes | Y | N |
| Corneal Disease | Y | N |
| Other | Y | N |

If yes, please explain (duration, treatment, surgery):

_____

_____

_____

_____

_____

_____

_____

_____

**Ocular Medications** –Please list name, dosage, frequency

_____

_____

_____

_____

_____

_____

_____

**Family and Social History** – Do any medical or eye diseases run in your family?

_____

_____

Do you smoke? Y N How much?_____ Do you drink alcohol? Y N How much?_____

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Patient Name:_____ D.O.B:_____ Date:_____

**Review of Recent Symptoms:**

Have you experienced the following symptoms recently? Please Check "Yes" or "No."

**Constitutional:**

- ☐ Yes ☐ No Chills or Fever
- ☐ Yes ☐ No Unusual fatigue
- ☐ Yes ☐ No Excessive Thirst
- ☐ Yes ☐ No Weight Change
- ☐ Yes ☐ No Pregnant

**Ears, Nose, Throat, Mouth:**

- ☐ Yes ☐ No Hearing Loss/Ringing
- ☐ Yes ☐ No Infection or Drainage
- ☐ Yes ☐ No Hoarseness
- ☐ Yes ☐ No Pain with Chewing

**Neurologic:**

- ☐ Yes ☐ No Muscle Weakness
- ☐ Yes ☐ No Numbness / Tingling
- ☐ Yes ☐ No Seizures / Convulsions
- ☐ Yes ☐ No Frequent Headache
- ☐ Yes ☐ No Dizziness
- ☐ Yes ☐ No Loss of Balance

**Bones and Joints:**

- ☐ Yes ☐ No Painful or Stiff Joints
- ☐ Yes ☐ No Swelling of Joints
- ☐ Yes ☐ No Back or Neck Pain
- ☐ Yes ☐ No Cramps in Muscles

**Skin:**

- ☐ Yes ☐ No Itching
- ☐ Yes ☐ No Rash or Hives
- ☐ Yes ☐ No Change in Skin / Mole
- ☐ Yes ☐ No Scalp Tenderness

**Heart:**

- ☐ Yes ☐ No Racing/Fluttering Heart
- ☐ Yes ☐ No Chest Discomfort
- ☐ Yes ☐ No Swollen Feet/Ankles

**Urinary:**

- ☐ Yes ☐ No Pain or Burn on Urination
- ☐ Yes ☐ No Penile Discharge
- ☐ Yes ☐ No Blood in Urine
- ☐ Yes ☐ No Vaginal/ Penile Ulceration

**Lungs:**

- ☐ Yes ☐ No Difficulty Breathing
- ☐ Yes ☐ No Wheeze / Asthma
- ☐ Yes ☐ No Shortness of Breath
- ☐ Yes ☐ No Cough

**Gastrointestinal:**

- ☐ Yes ☐ No Difficulty Swallowing
- ☐ Yes ☐ No Heartburn
- ☐ Yes ☐ No Nausea / Vomiting
- ☐ Yes ☐ No Change in Stools
- ☐ Yes ☐ No Abdominal Pain

**Mood:**

- ☐ Yes ☐ No Memory Change
- ☐ Yes ☐ No Change in Sleep
- ☐ Yes ☐ No Depression
- ☐ Yes ☐ No Excessive Worry
- ☐ Yes ☐ No Tense or Under Stress

**Blood:**

- ☐ Yes ☐ No Easy Bruising
- ☐ Yes ☐ No Prolonged Bleeding

I understand the above questions.
The answers given by me are correct to the best of my knowledge and belief.

Date:_____ Signature_____

# Financial Policies and Authorizations

Please read the following information before seeing the doctor, this is to eliminate any confusion regarding our office financial policy.

Medicare: Our doctor is participating with Medicare. We will be happy to submit any claims to Medicare and any medigap claims *one time* for you. If you do not have any secondary or supplemental coverage, you will be responsible for the 20% of what Medicare does not cover. There are certain tests and/or procedures that Medicare does not cover of which you will be notified and will be responsible for payment at the time of visit.

Medicaid: Our doctor is participating with Medicaid; we will file claims for you. You will be expected to pay any co-pays at the time of visit.

HMO & PPO: We will file claims for you as long as we are participating with your plan. You will be responsible for any co-pays, deductibles or services not covered at the time of your visit. *If your plan requires a referral/authorization from your primary care physician, you will be responsible for obtaining this prior to your visit.*

Private Pay: You will be responsible for payment in full the day of service. Please call our billing department for information at 303-261-1600.

## Insurance Signature-Authorization

*In cases for which insurance claims are filed the following form should be completed. In order for us to submit a claim on your behalf and request payment of insurance benefits either to myself or the party who accepts assignment, I understand that I, the patient, am financially responsible for bills submitted and for any balance not paid by insurance. A copy of this signature is as valid as the original.*

Patient acknowledgement and consent of notice of Privacy Practices for Protected Health information: I have received a copy of Notice of Privacy Practices for Protected Health Information. I grant consent to Colorado Retina Associates, P.C.; to use or disclose my personal health information to carry out treatment, payment or health care operations as described in the Notice of Privacy Practices for Protected Health Information.

I have read the above financial policy, Medicare/Insurance Signature Authorization, and Patient Acknowledgement & Consent of Notice of Privacy Practices for Protected Health Information completely; I understand and accept this policy.

_____

Signature of Patient Date

For Minors:

I, _____, give my permission for Colorado Retina Associates, P.C. to treat my child, _____.

Signature of Parent/ Guardian _____