REGISTRATION FORM

Welcome to Houston Retina Associates. We appreciate the opportunity of providing your eye care. Please complete the following information for our records. Thank You.

Today's date: _____/_____/_____

Name: _____ Sex: □ Male □ Female

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home: ( )_____ Work: ( )_____

Mobile: ( )_____ Fax: ( )_____

Date of birth:_____ SSN#: _____

Email Address: _____ Occupation: _____

Race: □ White □ Black / African American □ Asian / Pacific Islander □ Latino / Hispanic origin

□ American Indian / Alaskan Native □ Other: _____

Preferred language: _____

Marital status: Married / Single / Divorced / Separated / Widowed Spouse:_____

Referred by: _____ Phone:_____

Referring doctor's address:_____

Primary Medical Doctor Name: _____

Primary Medical Doctor Phone: _____

Medical Doctor Address:_____

Emergency Contact #1: _____ Phone:_____

Emergency Contact #2:_____ Phone:_____

Medical insurance (primary and secondary): _____

*** Policyholder name and date of birth: _____**

Policy No. _____ Group No. _____

*** Pharmacy Name:_____ Street: _____**

Phone: _____ City: _____

Houston Retina Associates, P.A.

Patient History Questionnaire

Name: **Date:**

Please state reason for visit:

Previous eye conditions and surgeries: ____ None

List ALL Medical Conditions: ____ None

___ Diabetes _____ years ___ High Blood Pressure ___ Heart Disease ___ HIV / AIDS
___ Kidney Dialysis/Disease ___ Bleeding Disorder ___ Cancer ___ Thyroid Disease
___ Lung Disease ___ Vascular Disease ___ Stroke ___ High Cholesterol

List Other Medical Problems and Major Surgeries: ____ None

List ALL Current Medications (include non-prescription drugs): ____ No medications

Allergies and Drug Reactions: ____ No known drug allergies

Social History: Circle answer

Do you drink alcohol? No Yes (if yes, how often?) _____
Do you currently smoke, chew, or use cigars?
No Yes (if yes, how often?) _____

If you no longer smoke, when did you quit? _____

Do you abuse drugs? No Yes (if yes, explain) _____
Do you drive? No Yes
Do you live alone? No Yes
Do you reside in a skilled nursing facility / assisted living? No Yes
Have you ever had a blood transfusion? No Yes

Family History:

Any relative with: ___ Glaucoma? _____
___ Macular Degeneration? _____
___ Other?: _____

Patient History Questionnaire

Name:	Date:

Review of Systems:

If you are currently having any problems in the following areas, please circle and explain.

CONSTITUTIONAL: fever, weight loss, fatigue, trouble standing from chair □ **none**

SKIN: itching, rash, infection, ulcer, tumors (growths), other: □ **none**

LYMPHATIC: swelling or tenderness of lymph nodes, other: □ **none**

MUSCULOSKELETAL: muscle pain, cramps, joint pain, swelling, other: □ **none**

ENDOCRINE: confusion, fainting, nervousness, hot/cold intolerance, hair loss □ **none**

ALLERGY/IMMUNOLOGY: recurrent infections, hay fever, hives, food/drug allergy □ **none**

HEAD: headaches, dizziness, vertigo, other □ **none**

EARS: hearing loss, ringing, infections, other □ **none**
NOSE: bleeding, loss of smell, congestion, sinus problems, other
THROAT: dry mouth, loss of taste, difficulty swallowing, hoarseness, other

NECK: pain, swelling, stiffness, other: □ **none**

BREAST: tenderness, swelling, lumps, discharge, other: □ **none**

HEMATOLOGIC: fever/chills; bruise easily, prolonged bleeding, skin hemorrhages □ **none**

RESPIRATORY: wheezing, cough, difficulty breathing, asthma, other: □ **none**

CARDIOVASCULAR: (heart/ blood vessels): chest pain, swelling of extremities, shortness of breath, exercise intolerance, other □ **none**

GASTROINTESTINAL: (stomach/intestines): nausea, vomiting, constipation, diarrhea, pain/cramps, bleeding, other □ **none**

GENITOURINARY: (genitals/kidney/bladder): frequency, burning, pain or bleeding on urination, infections, incontinence, other □ **none**

NEUROLOGIC: weakness in arms or leg, numbness, or tingling, loss of consciousness, falls, difficulty walking, seizures, tremors, neuralgia, other □ **none**

PSYCHIATRIC: disorientation, mood swings, anxiety, depression, hallucinations □ **none**

This form completed by: Patient Family Staff

***Dilation of Eyes*: Due to the nature of your eye problem, it will be necessary to put drops in your eyes, which will dilate them. This means that the pupils will become and stay enlarged, letting in more light and cause blurring of vision particularly at near. A few patients have expressed concern regarding their ability to function after dilation. It has been our experience that the near vision is affected far more than the distance, and that most individuals are able to "get around", although some caution may be necessary in order to give the doctor full enlarged view of the back of the eye. This is vital part of the retinal examination.**

***Assignment of Benefits*: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me.**

***Patient Financial Responsibility*: I understand that I am financially responsible for charges not covered by this assignment, including any insurance deductible, copayment, or any charges which the insurance carrier declines to pay. Any quote given by Houston Retina Associates is an estimated amount. It is further agreed that any credit balance resulting from payment of insurance or other sources may be applied to any other accounts allowed to send physician by the insured or his/her family. Any overpayment that I make to Houston Retina Associates will be applied as a credit to my account. If I prefer a refund, I will need to contact the billing department for that request and to confirm my mailing address to issue the refund. I understand that if for any reason my insurance company does not pay my bill within 90 days, I will be responsible. Any returned checks will incur a $20 returned checks fee. In the event the account becomes delinquent and is turned over to a collection agency, I responsible for any collection, court or attorney fees. If I would like a copy of the billing policy of Houston Retina Associates, it is available to me upon request by contacting the billing department.**

***Release of information*: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s), to the patient, to a family member, or employer of the patient for all or part of the physician(s) charge, including but not limited to insurance companies, workers compensation carriers, welfare funds, or the patient's employer. The physician may also disclose at his discretion all or part of the patient record to other health-care professionals and in their staff for the purpose of coordinating the patient's medical care. This includes but is not limited to the patient's primary care physician and referring physician. The patient or responsible party may request and receive all or part of the patient's record at anytime.**

***Medicare and Medicaid patients certification-payment classification authorization to release information and payment request*: I certify that information given by any and applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorized any holder of medical or other information about me to the Social Security Administration or its intermediary carriers, any information needed for this or any related Medicare, Medicaid or other third party claim. I request that payment of authorized benefits be made on my behalf. I signed benefits payable for physician(s) services. I understand that I am responsible for my health insurance collectibles and co-insurance.**

_____ _____

DATE **SIGNATURE OF PATIENT OR RESPONSIBLE PARTY**

Acknowledgement of Review of
Notice of Privacy Practices

As the law requires, neither your physician nor any member of his staff are permitted to give or discuss any information, whether written or oral, regarding your condition or treatment to any third party (relative, friend, co-worker, employer, etc.) without your express written authorization. However, a letter of consultation of your condition will be sent to the referring physician and your primary care doctor.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

Are there other family members or persons with whom you authorize us to discuss or release your medical information? □ Yes □ No If yes:

Name: _____

Phone: _____

Relationship: _____

Name: _____

Phone:_____

Relationship: _____

Designation of Authorized Representative

Member Name (*please print)*	DOB	Member ID number	
Member's Street Address	City	State	Phone

Name of Individual/Company/Law Firm being designated as the authorized representative

Houston Retina Associates

Designated Representative's Address	City	State	Phone
7789 Southwest Freeway, Ste 530	Houston	TX	281-495-2222

Provider Name:	Date(s) of service or proposed service
John J. Alappatt, Michael K. Lam, Lee T. Tran, Sapa T. Pham, Jie Gao, and Henry Lin	

I, _____ do hereby name

Print the name of the member who is receiving the service or supply

Houston Retina Associates

Print the name of the person who is being authorized to act on the member's behalf to act as my authorized representative in requesting *(check all that apply)*

☑ a complaint ☑ an appeal ☑ documents

from my insurance company regarding the above-noted service or proposed service.

I understand and agree that:

· This authorization is voluntary;

· my health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information:

· I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;

· my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulation;

· this authorization is valid until I revoke it in writing. I may revoke this authorization at any time by notifying my insurance company in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Signature of Member	Date

If person signing this authorization is not the member, describe relationship to the Member (i.e. Parent, Legal Representative)

Legal Representatives signing this authorization on behalf of a member must furnish a copy of a health care power of attorney, or other relevant document that grants the applicable legal authority

HOUSTON RETINA
ASSOCIATES

John J. Alappatt, MD
Jie Gao, MD
Michael K. Lam, MD
Henry Lin, M.D.
Sapa T. Pham, MD
Lee T. Tran, MD

Diseases & Surgery
of the
Macula, Retina & Vitreous

General Consent for Treatment

Treatment of your eye condition may include eye injections, laser surgery and cutting surgery.

Chronic conditions such as diabetic retinopathy, vein occlusion, macular degeneration and others are **never "cured" but are treated**. Treatment may take months or years before the condition becomes stable enough not to require further treatment.

Betadine antiseptic prep is used before eye injections and surgeries. The eye will be irritated on the day of the injection, but the eye should recover by the next day. Immediately **call our office at any time** for any persistent pain or blurred vision after the first day. All eye injections and eye surgeries have a risk of infection. An infection inside the eye can be treated; however, a severe infection can result in **loss of vision.**

Although the incidence of complications is low, all surgery involves risk that can result in loss of vision. Complications include infection, bleeding, stroke, retinal detachment, retinal swelling, high eye pressure, double vision and cataract (cloudy lens). These complications **may require additional procedures and surgeries.**

Overall, nearly all treatments will have a good result; however, there is **no guarantee of the outcome** from any treatment or surgery. In conditions such as macular hole, epiretinal membrane, and macula-off retinal detachment, the vision may not return to normal despite surgery as there may be permanent distortion and blurred vision due to the involvement of the center of the retina with these conditions. There is a small chance that a membrane can grow back after epiretinal membrane surgery.

I have read and understood the document above.

_____	_____	_____
Patient Signature	Patient Name	Date
_____	_____	_____
Witness Signature	Witness Name	Date