HEALTH HISTORY

NAME ______________________________ **DATE** ____________________

CHECK ALL THAT APPLIES

☐ Asthma
☐ Kidney Disease
☐ Tuberculosis
☐ Diabetes IDDM/ Type 2
Years__________
☐ Insulin
☐ Migraines
☐ Psychiatric/ Nervous disorder
☐ Temporal Arteritis
☐ Heart Disease

☐ Ulcer
☐ Hypertension
Years __________
☐ Sickle cell anemia
☐ Head or Spinal Injuries
☐ Seizures, Convulsions or fainting
☐ Extensive confinement by illness or in jury
☐ Elevated Cholesterol
☐ Stroke

☐ Carotid Artery Disease
☐ HIV/ AIDS
☐ WOMAN- Pregnant
☐ Tobacco use or have used Tobacco. Quit __________
☐ Do you use Alcohol?
☐ Do you use Street drugs?
☐ Other Diagnosed health Problems
____
____

Medical PCP: ______________________________

***Recent* changes to Health:** ______________________________

Please list the name, dosage, and frequency of all current Medications: (attach or use back of page)

____
____
____

Please list all medicines you are allergic to:

____
____

Your Ocular History: *Check all that applies* if diagnosed with any of the following in the past

Cataracts	Retinal Disease	Glaucoma	Other Eye Disorders __________

Have you had Eye Surgery? List Date(s) of Surgery

	RIGHT	**LEFT**
Cataract	__________	__________
Retinal	__________	__________
Other: __________	__________	__________

Surgical History Please Include *Date* and *Type*. (May Be Continued on Back of Sheet)

____
____
____

Family History: *Check all that applies* has anyone in your family (blood relative) had any of the following? NOTE RELATION TO PATIENT: F-Father, **M-**Mother, **P-**Paternal, **M-**Maternal, **S-**Sister, **B-**Brother, **GF-**Grandfather, **GM-**Grandmother, **U-**Uncle**, A-**Aunt

☐ Glaucoma __________
☐ Cataracts __________
☐ Corneal Disease __________
☐ Macular Degeneration __________
☐ Retinitis Pigmentosa __________
☐ Other Eye Problems __________

☐ Diabetes IDDM/Type 2 __________
☐ Heart __________
☐ Diabetic Retinopathy __________
☐ Retinal Detachment __________
☐ Stroke __________
☐ Other General Health Problems __________

Tech Initial: ______

Revised 6/2018

Registration

Warren Retina Associates, P.A.

Date: ___________________________

Patient ____

Last Name First Name Middle

Address ____

____

City State Zip Code

Sex: ☐M ☐F Birthdate____________ Marital Status: ☐SINGLE ☐MARRIED ☐WIDOW/ ER

_________________________________ _________________________________

Best phone number to reach you 2nd phone number

Employer __________________________________ Business Phone ____________________

Please complete the following information on the Policy Holder (if different from above):

Name ____ DOB __________________

Address ____ Phone __________________

Who is responsible for any unpaid balances? ***Circle: Self / Spouse / Policy Holder***

- ***Note that any delinquent financial account will be mailed to the Policy Holder if left unpaid.***

Warren Retina Associates may speak to my spouse.

Name ____ Phone___________________

Other Contacts:

____

Name Phone Relationship

____

Name Phone Relationship

I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR SERVICES RECEIVED WHICH ARE NOT COVERED BY INSURANCE BENEFITS DUE TO MY PARTICULAR POLICY.

SIGNATURE OF PATIENT ____
(PARENT IF UNDER 18 / POA)

Revised 6/2018

Keith A. Warren, M.D.

AUTHORIZATION TO RELEASE INFORMATION FOR ASSIGNMENT OF INSURANCE BENEFITS AND FOR OTHER CARE TAKERS

The undersigned hereby authorizes Keith A. Warren, M.D. to furnish such information and records concerning the named patient's medical condition to other health care providers, as deemed appropriate for continuity of care. The undersigned hereby authorizes Keith A. Warren, M.D. to release any such information and records to any insurance company, benefit plan, or governmental agency as may appear to be necessary to process any claim for medical services provided to the patient and, when approved by Keith A. Warren, M.D. hereby assigns to Keith A. Warren, M.D. and right to receipt of payment for such services, such payment to be made directly to Keith A. Warren, M.D. except as otherwise prohibited. Each person signing below acknowledges full responsibility for the payment of all charges incurred by the patient.
*If the patient is a minor or incompetent individual, the undersigned on behalf of such patients, does hereby consent to medical care, including diagnostic procedures, as determined by a physician or his assistants or designees to be necessary for the welfare of such patient. This authorization shall be in force without expiration of time limitations for any medical care provided by Keith A. Warren, M.D. his assistant or designee. The undersigned acknowledges that no guarantee has been made as to the results of any treatment, examination or test.

A photo static copy of this authorization shall be considered as effective and valid as the original.

Patient Name _______________________________________ DOB __________________

Patient Signature _______________________________________ Date ________________
(Parent if under 18 / POA)

Authorized Person _________________________ Relationship to Patient ________________

Keith A. Warren, M.D.

CONSENT FOR MEDICAL CARE

Recognizing the need for medical care, I do voluntarily consent to such care encompassing routine diagnostic procedures with the medical staff of Warren Retina Associates, P.A. and their assistants or designees on which decisions are made about my care. I also understand that I will be asked to sign separate consent forms for the authorization of any non- routine procedures and treatments.
I am aware that the practice of medicine is not an exact science and I will acknowledge that no guarantees have been made as to the result of the examination or medical treatment of Warren Retina Associates, P.A.

MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS DOCUMENTATION AND AM AUTHORIZING CONSENT FOR MEDICAL CARE.

Patient Signature ____ Date ________________
(Parent if under 18 / POA)

Authorized Person __________________________ Relationship to Patient ________________

Patient Rights and Responsibilities

1. You have the right to considerate and courteous care, with respect for your personal privacy, dignity, values and beliefs
    - *We ask that you follow our rules and respect our staff and facilities.*

2. You have the right to reasonable access to your health care services and to be given understandable instructions on how to obtain that care.
    - *We ask that you keep scheduled appointments or give adequate notice of cancellation and fulfill your financial obligations regarding your care.*

3. You have the right to know the names and qualifications of the people who provide and/ or are responsible for your health care.

4. You have the right to receive understandable information that enables you to participate in decision making, including advanced directives, ethical decisions and end-of-life decisions regarding your health care.
    - *We ask that you provide us to all the information we need to provide you with appropriate care and ask questions when you do not understand.*

5. So that you may give informed consent, you have the right to be adequately informed of your diagnosis and treatment plan.
    - *We ask that you follow the recommendations of your health care providers and/or consider the potential consequences of choosing not to do so.*

6. You have the right for your medical records to be kept confidential except when disclosure is required by law, is necessary for other providers to assist with your care, or as requested by you in writing.

7. You have the right to request access to protective services (for examples, guardianship or personal security) and we will contact the appropriate advocacy agency.

8. You have the right to express a complaint, to be informed of the person most to appropriate to deal with that complaint and to receive an answer in a reasonable period of time.

9. You have the right to appropriate assessment and management of pain.

10. You have the right to be respected and to have your health and well-being protected during participation in research, investigations or clinical trials.

I acknowledge that I have read my HIPAA rights as required by law.

Signed ____ Date ________________________