WillsEye Physicians
Mid Atlantic Retina

Patient Registration

Today's date: _____

Patient Information			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Please check Primary form of contact:	Home Phone ☐	Work Phone ☐	Cell Phone ☐
Other Name(s) Used		E-mail Address	
Gender ☐ M ☐ F	SSN	Preferred Language	Who referred you

Marital Status	**Preferred Contact**	**Ethnicity**	**Race**
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner	**Which form of communication do you approve for us to contact you?** ☐ Mail ☐ Home Phone ☐ Day Phone ☐ Cell Phone ☐ Patient Portal	☐ Hispanic/Latino ☐ Non-Hispanic ☐ unknown/or decline to answer	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other (decline to answer)

Primary Care Provider name	Referring Provider name	Cardiologist name	Endocrinologist Provider name
Address	Address	Address	Address

Responsible Party (Guarantor)		**Same as patient ☐**	
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Please check Primary form of contact:	Home Phone	Work Phone	Cell Phone
SSN	Relationship to Patient	Preferred Language	Driver's License

Emergency Contact (for minor child, this section may be used for other parent)			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

Insurance information (Please complete all details)			
Primary insurance	ID # and Group #	DOB	Subscriber and relationship
Secondary insurance	ID # and Group #	DOB	Subscriber and relationship

I/We do hereby consent to and authorize the performance of all medical services and treatments deemed advisable by the physicians and staff of Mid Atlantic Retina (MAR) to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained herein are true. I understand that, although the providers of MAR may or may not participate with my insurance carrier(s), I am financially responsible for any co-payments, deductibles, and payment for non-covered services or out of network services incurred for myself and/or my dependent(s). I furthermore agree to pay accrued interest, if applicable, collection expenses, and reasonable attorneys' fees incurred to collect any amount I may owe. I also hereby authorize MAR to release information as necessary for and/or requested by the insurance company and/or its representatives for claims processing and payment. I fully understand this agreement and consent will continue until cancelled by me in writing.

Signature of Patient/Responsible Party	Date
Name of Patient/Responsible Party (Please Print)	Relationship to Patient

Name: _____ DOB:_____

Pharmacy Information	
Preferred Pharmacy	**Secondary Pharmacy**
Name	Name
Address	Address
Phone	Phone
Fax	Fax

Advanced Directives

☐ None ☐ Do Not Resuscitate ☐ Durable ☐ Power of Attorney ☐ Living Will ☐ HC Proxy

Date Reviewed:

Medications – List all medications you take, prescription and non-prescription, and the dosage

☐ I do not take any medications

Medication Name	Dosage/Strength	Medication Name	Dosage/strength

Medication and Food Allergies – List all known allergies (drugs, food, animals, etc.)

☐ No Known Allergies

Family History – Check if any family member(s) has had any of the following conditions.

☐ Adopted

Diagnosis	
Anemia	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: _____
Arthritis	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: _____
Blindness	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: _____
Cancer (type)	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: _____
Cataract	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: _____
Diabetes	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: _____
Diabetic Retinopathy	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: _____
Glaucoma	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: _____
Heart Disease	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: _____
Hepatitis	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: _____
Hypertension	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: _____
Kidney Disease	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: _____
Macular Degeneration	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: _____
Retinal Detachment	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: _____
Stroke	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: _____
Tuberculosis	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: _____
Thyroid Disease	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: _____
Uveitis	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: _____

Name: _____ DOB:_____

Medical History – Check if you have ever experienced the following conditions, and year of onset.			
Condition	**Year**	**Condition**	**Year**
☐ None		☐ Lyme Disease **With Arthritis** ☐ **Y**	
☐ Alzheimers		☐ Mania/Bipolar	
☐ Amputation Location:_____		☐ Marfan's Syndrome	
☐ Anemia		☐ Migraines	
☐ Arthritis **Rheumatoid?** ☐ **Y** Location: _____		☐ Mitral Valve Proplapse	
☐ Asthma		☐ **Multiple Sclerosis**	
☐ Atrial Fibrillation		☐ **Myasthenia Gravis**	
☐ Blood Clots		☐ Neurofibromatosis Type: ☐ 1 ☐ 2	
☐ Bronchitis		☐ Osteoporosis	
☐ Cancer – Type : _____		☐ Psychosis	
☐ Cardiovascular Disease		☐ Sarcoidosis: ☐ Lung ☐ Lymph Node ☐ Lung & Lymph nodes ☐ Other: _____	
☐ COPD		☐ Schizophrenia	
☐ **Crohn's Disease**		☐ Seizure	
☐ Depression		☐ **Sickle Cell**: ☐ **Anemia** ☐ **Hb-C**	
☐ **Diabetes** (**see questions below**)		☐ Sinusitis	
☐ Diverticulitis		☐ **Sjogren's Syndrome**	
☐ Emphysema		☐ Steroid Therapy (long term)	
☐ **ESRD**		☐ **Stevens-Johnson Syndrome**	
☐ Hearing Loss		☐ Stickler Syndrome	
☐ Heart Attack		☐ Stroke	
☐ Heart Murmur		☐ Thyroid condition	
☐ Hepatitis (Type) ☐ A ☐ **B** ☐ **C**		☐ Temporal Arteritis	
☐ **HIV**		☐ Transplant Recipient ☐ Kidney ☐ Heart ☐ Bone Marrow ☐ Pancreatic ☐ Other: _____	
☐ Hypercholesterolemia		☐ Tuberculosis	
☐ Hypertension		☐ **Ulcerative Colitis**	
☐ Irregular Heart Beat		☐ Ulcers	
☐ **Juvenile Rheumatoid Arthritis** **Location:** _____		☐ Urinary Infections	
☐ Kidney Disease Stage: ☐ 1 ☐ 2 ☐ 3 ☐ **4** ☐ **5**		☐ **Von Hippel-Lindau Syndrome**	
☐ **Lupus**		☐ Other	

Diabetes

Diabetes Type: ☐ 1 ☐ 2 Year Diagnosed _____ Are you on insulin? ☐ **Yes** ☐ No x per day _____

What is Hgb A1C? _____ Recent Range: From _____ to_____ Do you test at home? ☐ Yes ☐ No

Are you on dialysis? ☐ **Yes** ☐ No Frequency? _____/week

Name: _____ DOB:_____

Please list any prior eye problems & treatments:		
☐ Y ☐ N	Glaucoma	treatment:
☐ Y ☐ N	Macular Degeneration	treatment:
☐ Y ☐ N	Diabetic Retinopathy	treatment:
☐ Y ☐ N	Other	treatment:

Surgical History – Check if you have received the following procedures, and year performed.

Non- Ocular Surgeries		Ocular Surgeries	
Surgical Procedure	**Date**	**Cataract Surgery**	**Date**
		Right eye	
		Left eye	
		Retinal Surgery	
		Right Eye	
		Left Eye	
		Other:	

Social History

Marital Status: ☐ Married ☐ Single ☐ Widow/Widower ☐ Divorced ☐ Separated

Do you smoke cigarettes/cigars? ☐ yes ☐ no Number per day:_____ Years Smoked:_____ Year quit: _____

Do you drink alcohol? ☐ yes ☐ no How much? _____ How often?_____

Past and present drug use (legal or illegal) is important for drug and anesthetic interactions. Please indicate if we need to be aware of this: ☐ yes ☐ no

What is your occupation? _____ Are you still working? ☐ yes ☐ no

Have you had a blood transfusion since 1977? ☐ yes ☐ no When?_____

Living Conditions: ☐ alone ☐ nursing home ☐ caretaker/family ☐ other_____

Do you have or have you ever had any pets? ☐ yes ☐ no What kind?_____

Do you exercise? ☐ yes ☐ no What kind?_____ How often?_____

Review of Systems (check all that apply)

Constitutional □ Jaw Pain □ Fever □ Weight Loss □ Fatigue □ Loss of Appetite □ Trouble Sleeping □ Other	**Cardiovascular** □ Chest Pain □ Swelling of Feet	**Endocrine** □ Excessive Thirst □ Excessive Urination □ Cold Intolerance □ Heat Intolerance □ Other	**Gastrointestinal** □ Abdominal Pain □ Nausea □ Diarrhea □ Constipation □ Other
HENT □ Hearing Loss □ Sore Throat □ Runny Nose □ Other	**Neurologic** □ Weakness □ Headaches □ Scalp Tenderness □ Dizziness □ Paralysis of Extremities □ Tremor	**Genitourinary** □ Pain/Burning with Urination □ Other	**Integumentary** □ Rash □ Change in Mole
Respiratory □ Wheezing □ Cough □ Shortness of Breath □ Other	**Hematology / Oncology** □ Easy Bruising □ Prolonged Bleeding □ Clotting Problems □ Other	**Musculoskeletal** □ Muscle Aches □ Joint Pain □ Difficulty Laying Flat from Muscular Discomfort	