Retina of Illinois, S.C. - Aashish V. Gandhi, MD, FACS
PATIENT INFORMATION

Patient Name _____ Date of Birth _____
Last First Middle Initial

Social Security Number _____ Referred by_____

Address _____ City_____ State _____ Zip_____

Home Phone _____ Cell Phone _____ Email _____

Work Phone _____ Occupation_____

Emergency Contact _____ Phone _____

Responsible Party if Other than Patient: _____ _____ _____
Name DOB Phone Number

For Demographic Use:

Preferred Language: ____English ____Spanish ____Other _____ **Gender:** ¡ Male ¡ Female
Race: ____American Indian or Alaska Native ____Asian ____Black or African American
____Caucasian ____Native Hawaiian or Other Pacific Islander
Ethnicity: ____Hispanic or Latino ____Not Hispanic or Latino

Marital Status: ¡ Married ¡ Single ¡ Widowed ¡ Other

FINANCIAL POLICY & AGREEMENT

Patient Financial Responsibility: We expect you to be financially responsible for payment of your medical care at Retina of Illinois, S.C. All accounts are payable in full at time of service; a courtesy period of 45 days is given on all insurance claims. If after 45 days insurance payment is not received, the balance in full becomes your responsibility.

Financial Agreement: I hereby authorize release of any information to my insurance carrier regarding my claim. I also authorize my insurance benefits to be paid directly to Retina of Illinois, S.C. My signature below indicates this authorization. I have read the above, understand and agree to it.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing this form, you consent to our use and disclosure of Protected Health information about you for non-subsidized treatment, payment and health care operations, and for other purposes as permitted or required by law. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I authorize the person(s) listed below to discuss or receive my protected health information:

Name:_____Relationship:_____

Name:_____Relationship:_____

Patient Signature: _____Date:_____

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PATIENT MEDICAL INFORMATION

Patient Name:_____ DOB:_____

Primary Care Physician:_____ **Height** _____ **Weight** _____

Allergies: _____No Known Drug Allergies (NKDA): ☐

Ocular & Other Medication(s) Information No Ocular Meds ☐ No Other Meds ☐

Please list ALL prescribed medications including EYE drops and EYE medications (Herbal and Dietary Supplements should also be listed)

Medication	Strength	How many/ How much	How Often

Surgical History No Prior Surgical History ☐

Please list all prior EYE surgeries, EYE procedures, and ANY OTHER surgeries/procedures

Surgery/Procedure	Date	Performing Physician

Family History

Do any blood relatives, LIVING or DECEASED, have any of the following conditions?

Condition	Relation/Status	Condition	Relation/Status
Diabetes		Macular Degeneration	
High Blood Pressure		Hereditary Eye Disease	
Heart Disease		Diabetic Retinopathy	
Stroke		Glaucoma	
Cancer		Retinal Detachment	

Patient Name:_____ DOB:_____

Medical History

When were you last examined by an ophthalmologist or optometrist? Date:_____ Doctor:_____

OCULAR No Past Ocular History ☐

Have you ever had?	Y	N	Date of Onset
Retinal Detachment			
Diabetic Retinopathy			
Macular Degeneration			
Hereditary Eye Disease			
Glaucoma			
Retinal Vein Occlusion			
Ocular Migraines			
Amblyopia (lazy eye)			
Glaucoma			
Cataracts			
Extreme Dry Eyes			
Other:			

OTHER No Past Medical History ☐

Have you ever had?	Y	N	Date of Onset
Diabetes: Type I or Type II			
Diabetic Retinopathy			
High Blood Pressure			
Heart Problems			
Asthma/Emphysema/TB/ COPD			
Kidney Problems? Dialysis			
Cancer			
Weak Immune System			
High Cholesterol			
Other Illnesses:			

Social History

SMOKING/TOBACCO ☐Never ☐Former ☐Current How much?_____
ALCOHOL ☐Never ☐Former ☐Current How much?_____

REVIEW OF SYSTEMS – Indicate if you have any of the following

☐All systems reviewed with **NEGATIVE RESPONSES**

Ocular
- ☐ Blurred vision
- ☐ Double vision
- ☐ Eye pain
- ☐ Flashes/Floaters
- ☐ Recent loss of vision
- ☐ Redness

Allergy/Immunology
- ☐ Autoimmune disease
- ☐ Eczema
- ☐ Food
- ☐ Seasonal allergies

Cardiovascular
- ☐ Chest pain/pressure
- ☐ Shortness of breath
- ☐ Swelling of feet/ankles

Constitutional
- ☐ Difficulty sleeping
- ☐ Feeling of weakness
- ☐ Fever
- ☐ Hot flashes
- ☐ Loss of appetite
- ☐ Unexplained weight loss

Endocrine
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Fatigue

Gastrointestinal
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn or indigestion
- ☐ Vomiting
- ☐ Reflux

Genitourinary
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Kidney failure
- ☐ Painful urination
- ☐ Vaginal discharge

Hematology/Oncology
- ☐ Difficulty swallowing
- ☐ Frequent headaches
- ☐ Hearing loss
- ☐ Ringing in ears

Integumentary
- ☐ Recent hair loss
- ☐ Skin cancer
- ☐ Skin rashes
- ☐ Skin sores

Musculoskeletal
- ☐ Arthritis
- ☐ Joint pain
- ☐ Muscle aches

Neurological
- ☐ Confusion
- ☐ Dementia
- ☐ Headaches or migraines
- ☐ Numbness
- ☐ Poor balance

Psychiatric
- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Depression

Respiratory
- ☐ Coughing
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Wheezing