MEDICAL HISTORY UPDATE

Name_____Birthdate_____Date_____

Referring Physician_____

Primary Care Physician, Internist or Endocrinologist_____

Have you been diagnosed with any of the following?

	Yes	No	Date of Onset
High Blood Pressure	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
Lung Disease	☐	☐	_____
Stroke	☐	☐	_____
Cancer	☐	☐	_____
Migraine	☐	☐	_____

Please list any other conditions for which you have been under medical care.

_____

_____

List all medications including vitamins & herbal supplements.
Any changes to medications since last visit? Yes ☐ No ☐

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Are you allergic to any medications? Yes ☐ No ☐
If YES, list medications _____

Are you allergic to Latex? Yes ☐ No ☐
Any additional surgeries since last visit, including eye surgeries, and date of each

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Any Problems with anesthetics (Local or General)? Yes ☐ No ☐
If YES, please describe _____

Have you had a MRI or CT Scan? Yes ☐ No ☐
If YES, what were the results _____

History Reviewed.
Date _____ M.D. Signature Required _____

HIGHLAND RETINA ASSOCIATES

PATIENT REGISTRATION UPDATE

Patient Name: _____ Date: _____

Date of Birth: _____ Age:_____ Social Security #: _____
Current Address: _____Apt #: _____City: _____State: ____ Zip: _____
Employer Name: _____ Occupation: _____
Employer Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (_____) _____ Work Phone: (_____) _____ Mobile: (_____) _____
Email Address: _____

Preferred Method of Phone Contact: ☐ Mobile ☐ Home ☐ Work (please check one)

Are you currently staying at a Rehab Center or Skilled Nursing Home? ☐ Yes ☐ No

If Yes, Name of Facility: _____ Phone #: _____

Are you currently enrolled in Hospice? ☐ Yes ☐ No

If Yes, Date enrolled: _____ Name of Hospice Company: _____

MEDICAL INSURANCE INFORMATION

Primary Insurance Carrier: _____
Secondary Insurance Carrier: _____
We will need to make a copy of your current insurance cards

How is the "Insured" party related: ☐ Self ☐ Guarantor ☐ Spouse

Spouse's Name: _____ Date of Birth: _____ Social Security #: _____
Does your insurance company require a formal authorization or referral from a Primary Care Physician for our services?
☐ Yes ☐ No If Yes, Physician's Name: _____

PRIMARY CARE PHYSICIAN

Have you changed Primary Care Physician? ☐ Yes ☐ No

If Yes, Physician's Name: _____ Phone #: (_____) _____
Primary Care Physician's Address: _____ City: _____State: ____ Zip: _____
Preferred Pharmacy Name: _____ Phone #: (_____) _____
Preferred Pharmacy Address: _____ City: _____State: ____ Zip: _____