# Retina Consultants of Oklahoma, PLLC

## Patient Information Sheet

Date: ___________________

First Name: _________________________ MI: ______ Last Name: ____________________________

Preferred Name: _____________________

Address: ______________________________ City: ______________ State: _______ Zip: _________

Phone: (____) ______________ Wk. Phone: (____) ______________ Cell: (____) ______________

Date of Birth: ______________ Age: _____ Height: ______ Weight: ______ Sex: ❑ Male ❑ Female

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Other ___________________

Social Security #: ____________________ ❑ Retired ❑ Working Full-Time ❑ Working Part-Time

Race/Ethnicity: ❑ American Indian ❑ Asian or Pacific Islander ❑ Hispanic ❑ Non-Hispanic
❑ Black ❑ White ❑ Other ❑ Unknown

Employer: ____________________________ Employer's Address: ____________________________

City: ______________________________ State: ____________ Zip: _______________

---

**Insurance Information**

Primary Insurance: _________________________I.D. #: ________________ Group #: ____________

Secondary Insurance: _______________________I.D. #:________________ Group #: ____________

---

**Primary Insured/Responsible Party Information**
**(if different from patient)**

First Name: _________________________ MI: ______ Last Name: ____________________________

Address: ____________________________ City: _________________State: _______ Zip: _________

Phone: (____) ______________ Wk. Phone: (____) ______________ Cell: (____) ______________

Date of Birth: __________________ Age: _______ Sex: ❑ Male ❑ Female

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Other ___________________

Social Security #: __________________ ❑ Retired ❑ Working Full-Time ❑ Working Part-Time

Employer: ____________________________Employer Address: ______________________________

City: ______________________________ State: ____________ Zip: _______________

---

Whom may we thank for referring you? Dr. ______________________________

Referring Doctor's Address (If known): ______________________________

---

What doctor do you normally see for glasses? ______________________________

Doctor's Address (If known): ______________________________

Phone: (____) ______________ Date of Last Eye Exam: ______________________

Do you wear glasses? ❑ Yes ❑ No (If yes, at what age did you first get glasses? ____________)
(If yes, how old are your current glasses? ______________)

Do you wear contacts? ❑ Yes ❑ No

---

**Eye Health**

Please check any current eye problems or symptoms you are currently having difficulty with:

| | | | |
|---|---|---|---|
| ❑ READING | ❑ DRIVING | ❑ DRY EYES | ❑ EYE ITCH |
| ❑ WATCHING TV | ❑ STREET SIGNS | ❑ WATERY EYES | ❑ EYE BURN |
| ❑ GLARE | ❑ SUNLIGHT | ❑ NIGHT DRIVING | ❑ EYES FEEL SANDY |

Other: ______________________________________________

Have you ever been told you have glaucoma? ❑ Yes ❑ No

Have you ever been told you have cataracts? ❑ Yes ❑ No (If yes, when?) ________________

Have you ever had any type of eye surgery (i.e. Lasik)? ❑ Yes ❑ No (If yes, please explain) ______

______________________________________________

Have you ever had an eye injury? ❑ Yes ❑ No (If yes, please explain) ____________________

______________________________________________

Do you use eye drops? ❑ Yes ❑ No (If so, what kind?) ____________________________

---

**General Health**

Please list all prescription medications you are currently taking: ________________________

______________________________________________

______________________________________________

Please list any medications you are **ALLERGIC** to: ______________________________

______________________________________________

Do you take a blood thinner or aspirin? ❑ Yes ❑ No (If yes, which and what dose?) _____________

Do you smoke? ❑ Yes ❑ No Do you drink? ❑ Yes ❑ No Do you exercise? ❑ Yes ❑ No

Please circle "Yes or "No" to indicate if you have or have had any of the following:

Yes No AIDS/HIV
Yes No Arthritis
Yes No Asthma/COPD
Yes No Bleeding
Yes No Blood Clots
Yes No Cancer- *If yes, what type?* ___________________________
Yes No Depression
Yes No Drug Dependency
Yes No Dry Eyes
Yes No Diabetes
Yes No Emphysema
Yes No Heart Condition- *If yes, what kind?* ______________________
Yes No Hepatitis- *If yes, what type?* ___________________________
Yes No High Blood Pressure
Yes No Kidney Disease
Yes No Lupus
Yes No Migraine Headaches
Yes No Pace Maker
Yes No Seizures
Yes No Sleep Apnea
Yes No Stroke- *If yes, date:* ___________________________

Please list all major surgeries and/or illnesses you have had: _________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Please circle "Yes or "No if anyone in your family has had a history of any of the following:

Yes No Cataracts
Yes No Diabetes
Yes No Macular Degeneration
Yes No Glaucoma
Yes No Retinal Problems

---

**Privacy/Emergency Contact Information**

Relative/Friend whom we may contact regarding your visits and/or in the event of an emergency:

1.____________________________ Relationship _______________ Phone #: (____) ___________

2.____________________________ Relationship _______________ Phone #: (____) ___________

If our office is unable to reach you by phone, may we leave voicemails regarding your appointments?
❑ Yes ❑ No

I certify that I have been provided the Retina Consultants of Oklahoma Notice of Privacy Practices:

___________________________________ _____________________ ________________________
Patient Signature Date Retina Cons of OK Employee

___________________________________________________________________________________

## Authorization for Release of Information

I, ____________________________, authorize the release of my protected health information to the person or persons named below.

1. ____________________________ Relationship ________________ Phone #: (____) ____________

2. ____________________________ Relationship ________________ Phone #: (____) ____________

3. ____________________________ Relationship ________________ Phone #: (____) ____________

4. ____________________________ Relationship ________________ Phone #: (____) ____________

5. ____________________________ Relationship ________________ Phone #: (____) ____________

Information that may be released to the persons listed above:

Financial Information: ❑ Yes ❑ No
In-Office Information: ❑ Yes ❑ No
Surgery Information: ❑ Yes ❑ No

### Rights of the Patient

I understand that I have the right to revoke this authorization at any time. I understand that a revocation is not effective in cases where the information has already been disclosed.
I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

Patient's Signature ____________________________________________ Date: ___________________

---

### Authorization of Care

I authorize Retina Consultants of Oklahoma, PLLC to examine me and perform such tests and procedures as are reasonable and necessary in the diagnosis and treatment of my care. If I am not the patient, but instead signing on behalf of the patient, I further certify that I am **legally authorized** to sign on the patient's behalf.

Patient's Signature ____________________________________________ Date: ___________________

Representative's Signature ____________________________________ Date: ___________________

Relationship of Representative to patient ___________________________________________________