RETINA SPECIALISTS of Mississippi

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109 MILLSAPS DRIVE, SUITE B HATTIESBURG, MS 39402
P: (601) 255-0736 F: (601) 255-0735

PATIENT INFORMATION

Name (First, Middle, Last):
Preferred Name: Gender: Marital Status:
Date of Birth: Social Security #:
Mailing Address:
City: State: Zip Code:
Home Phone: ( ) Cell Phone: ( )
Language: Race:
Contact Method: ☐ Call ☐ Text E-Mail:
Occupation: Work Phone: ( )
Employer:
Employer Address:
City: State: Zip Code:
Referring Doctor:
Primary Care Doctor:

SPOUSE'S INFORMATION *Required if spouse is primary policy holder of patient's insurance*

Name (First, Middle, Last):
Date of Birth: Social Security #: Gender:
Mailing Address:
City: State: Zip Code:
Home Phone: ( ) Cell Phone: ( )
Employer: Work Phone: ( )

EMERGENCY CONTACT *Required if emergency contact is not spouse*

Name: Phone: ( ) Relationship:
Address:
City: State: Zip Code:

RESPONSIBLE PARTY / GUARANTOR INFORMATION *Required if patient is a minor*

☐ Same as patient
Name (First, Middle, Last):
Date of Birth: Social Security #:
Relationship: Gender:
Mailing Address:
City: State: Zip Code:
Home Phone: ( ) Cell Phone: ( )
Employer: Work Phone: ( )

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder's Name: _____ Policy Holder's Name: _____

Policy Holder's DOB: _____ Policy Holder's DOB: _____

Policy Holder's SSN: _____ Policy Holder's SSN: _____

Policy ID: _____ Policy ID: _____

Group Number: _____ Group Number: _____

☐ No Insurance/Self Pay ☐ Worker's Compensation ☐ Vocational Rehabilitation

Resident of a Skilled Nursing Facility? ☐ No ☐ Yes: _____

Name of Skilled Nursing Facility

INSURANCE AND/OR CASE POLICY AUTHORIZATION

Medicare, Medicaid, commercial/private insurance, and all relevant case policies

I understand that Retina Specialists of Mississippi, PLLC (RSM) accepts assignment of benefits from Medicare, Medicaid, and various commercial/private insurance companies. I authorize RSM to release information concerning healthcare, advice, treatment, and supplies to the Center for Medicare Services, the Division of Medicaid, commercial/ private insurance companies, and/or state agencies, for evaluation and administration of claims of benefits. I authorize payment of claims of benefits to RSM for any services rendered by RSM, or its authorized agents. I have been provided with a copy of RSM's Financial policy. I understand and consent to this policy. As the patient or guarantor, I understand that I am financially responsible for any amount not covered by my insurance or case policy; such as any co-payment, deductible, and/or co-insurance assigned to me. I acknowledge that non-payment of my account may result in financial penalties, collections proceedings, and/or dismissal from the practice. I acknowledge that any fees associated with the collections process and/or legal action taken to resolve any outstanding financial matters will be my responsibility. I authorize the release of any medical information necessary to process all claims, and I authorize the release of payment for medical benefits to Retina Specialists of Mississippi, PLLC.

Signature: _____ Date: _____

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been provided with a copy of the Health Insurance Portability and Accountability Act of 1966 (HIPAA). I understand and consent to RSM's use and disclosure of my protected health information for treatment, payment, and health care operations. I authorize RSM, or its authorized agents, to disclose general medical information and other protected health information (PHI) to the following persons and/or entities listed below. If no one is listed below, general medical information and other PHI will only be disclosed in those situations described in the Notice of Privacy Practices.

Person Or Entity Name	Relationship to Patient
1.	
2.	
3.	

Signature: _____ Date: _____

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Routine Medications (Please include dosage if known): _____

_____

_____

_____

_____

Allergies to Medications (Please include reaction): _____

_____

Have you received the flu vaccine this year? ☐ No ☐ Yes

Have you received the pneumonia vaccine in the past 5 years? ☐ No ☐ Yes

List any surgeries you've had in the past: _____

_____

_____

REVIEW OF SYSTEMS

Are you PRESENTLY *experiencing any of the following symptoms? If "Yes", when did the symptoms begin?*

Blurred Vision . . . . . ☐ No ☐ Yes: _____
Sudden Vision Loss . . . . . ☐ No ☐ Yes: _____
Fever . . . . . ☐ No ☐ Yes: _____
Fatigue . . . . . ☐ No ☐ Yes: _____
Weight Loss / Loss of Appetite . . . . ☐ No ☐ Yes: _____
Hearing Loss . . . . . ☐ No ☐ Yes: _____
Sore Throat . . . . . ☐ No ☐ Yes: _____
Runny Nose . . . . . ☐ No ☐ Yes: _____
Shortness of Breath . . . . . ☐ No ☐ Yes: _____
Chest Pain . . . . . ☐ No ☐ Yes: _____
Cough / Wheezing . . . . . ☐ No ☐ Yes: _____
Frequent Urination . . . . . ☐ No ☐ Yes: _____
Nausea/Vomiting . . . . . ☐ No ☐ Yes: _____
Diarrhea . . . . . ☐ No ☐ Yes: _____
Pain with Urination . . . . . ☐ No ☐ Yes: _____
Rash . . . . . ☐ No ☐ Yes: _____
Joint Pain . . . . . ☐ No ☐ Yes: _____
Muscle Aches . . . . . ☐ No ☐ Yes: _____
Dizziness . . . . . ☐ No ☐ Yes: _____
Headaches . . . . . ☐ No ☐ Yes: _____
Paralysis of Extremities . . . . . ☐ No ☐ Yes: _____

Are you now, or have you ever been, a smoker? If "Yes", how many packs per day, or when did you quit smoking? ☐ No ☐ Yes: _____

Do you drink alcohol? If "Yes", how many alcoholic beverages per day?

☐ No ☐ Yes: _____

PERSONAL MEDICAL HISTORY

Have you recently had, or are you currently managing, any of the following medical conditions? If "Yes", explain.

Blindness . . . . . ☐ No ☐ Yes: _____
Cataract . . . . . ☐ No ☐ Yes: _____
Glaucoma . . . . . ☐ No ☐ Yes: _____
Macular Degeneration . . . . . ☐ No ☐ Yes: _____
Retinal Detachment . . . . . ☐ No ☐ Yes: _____
Arthritis . . . . . ☐ No ☐ Yes: _____
Cancer . . . . . ☐ No ☐ Yes: _____
Diabetes . . . . . ☐ No ☐ Yes: _____
If "YES", do you use insulin? ☐ No ☐ Yes
If "YES", what was your most recent A1C result: _____
Cardiac/Vascular Disease . . . . . ☐ No ☐ Yes: _____
Stroke . . . . . ☐ No ☐ Yes: _____
Thyroid Disease . . . . . ☐ No ☐ Yes: _____
High Blood Pressure . . . . . ☐ No ☐ Yes: _____
Kidney Disease . . . . . ☐ No ☐ Yes: _____
If "YES", are you on Dialysis? ☐ No ☐ Yes
Stomach Ulcer . . . . . ☐ No ☐ Yes: _____
Asthma . . . . . ☐ No ☐ Yes: _____
Emphysema . . . . . ☐ No ☐ Yes: _____
COPD . . . . . ☐ No ☐ Yes: _____
HIV . . . . . ☐ No ☐ Yes: _____
AIDS . . . . . ☐ No ☐ Yes: _____
Sickle Cell/Trait . . . . . ☐ No ☐ Yes: _____
Dementia . . . . . ☐ No ☐ Yes: _____
Parkinson's . . . . . ☐ No ☐ Yes: _____
Tourette's . . . . . ☐ No ☐ Yes: _____

FAMILY MEDICAL HISTORY

Has anyone in your family had any of the following medical conditions? If "Yes", which family member had the condition?

Blindness . . . . . ☐ No ☐ Yes: _____
Cataract . . . . . ☐ No ☐ Yes: _____
Glaucoma . . . . . ☐ No ☐ Yes: _____
Macular Degeneration . . . . . ☐ No ☐ Yes: _____
Retinal Detachment . . . . . ☐ No ☐ Yes: _____
Arthritis . . . . . ☐ No ☐ Yes: _____
Cancer . . . . . ☐ No ☐ Yes: _____
Diabetes . . . . . ☐ No ☐ Yes: _____
Heart Disease/Heart Attack . . . . . ☐ No ☐ Yes: _____
High Blood Pressure . . . . . ☐ No ☐ Yes: _____
Kidney Disease . . . . . ☐ No ☐ Yes: _____
Stroke . . . . . ☐ No ☐ Yes: _____
Thyroid Disease . . . . . ☐ No ☐ Yes: _____
Other . . . . . ☐ No ☐ Yes: _____

Please provide any other information that you think the doctor should know: _____
_____

Patient Signature: _____ Date: _____

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AUDIO / VIDEO RECORDING POLICY:

I understand that Retina Specialists of Mississippi, PLLC, is required by state and federal law to maintain the confidentiality, privacy, and security of medical information. To comply with these requirements, Retina Specialists of Mississippi, PLLC does not allow patients or other individuals to make any audio or video recordings while at the clinic. I understand and agree to abide by this policy. I agree not to make, or allow others accompanying me during my visit to make, any audio or video recordings in any form while at the clinic, including any recordings of my interactions with the treating physician or other healthcare personnel of Retina Specialists of Mississippi, PLLC. I further understand that if I require some accommodation to understand any information provided to me during my visit that I should inform my treating physician or other healthcare personnel, and that Retina Specialists of Mississippi, PLLC will provide a reasonable accommodation to ensure that I am adequately informed.

_____

Printed name of the Patient or Patient Representative

_____ _____

Signature of the Patient or Patient Representative **Date**