Ophthalmology

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Retina, Macula, and
Vitreous Diseases

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Dear Patient,

Thank you for choosing Bethesda Retina for your ophthalmology services!

Because you are a new patient with us, we are providing you this paperwork so that it can be filled out prior to your scheduled appointment. Please reference the checklist below to make sure you have all the necessary information that we require.

And please make sure to bring with you:

- ☐ **Medical insurance card(s) and a photo ID.**
- ☐ **The Registration and Patient History forms included in this packet, completely filled in.**
- ☐ **A list of all medications currently being taken, including their dosages and frequency.**
- ☐ **Your referral, if required by your insurance. Please make sure the referral is not expired, and that it states on it "Medical Eye Exam" and "Evaluate and Treat".**

Thank you and we look forward to seeing you for your appointment!

BETHESDA RETINA, LLC | Dr. S. M. Sastry

PATIENT REGISTRATION FORM

(PLEASE PRINT CLEARLY)

NAME _____ **DATE** _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIPCODE** _____

HOME PHONE _____ **WORK PHONE** _____

CELL PHONE _____ SOCIAL SECURITY # _____

DATE OF BIRTH _____ AGE _____ SEX _____ MARITIAL STATUS _____

EMAIL ADDRESS _____

OCCUPATION _____

EMPLOYER _____ FULL/PART TIME _____

EMERGENCY CONTACT _____

EMERGENCY CONTACT PHONE _____ RELATIONSHIP _____

(The persons to whom you are authorizing us to disclose your protected health information if needed)

ADDITIONAL CONTACT (IF ANY) _____

ADDITIONAL CONTACT PHONE _____ RELATIONSHIP _____

PRIMARY INSURANCE COMPANY _____

POLICY HOLDER (IF OTHER THAN YOURSELF) _____

RELATIONSHIP _____ D.O.B. _____ S.S. # _____

SECONDARY INSURANCE COMPANY _____

POLICY HOLDER (IF OTHER THAN YOURSELF) _____

RELATIONSHIP _____ D.O.B. _____ S.S. # _____

PRIMARY CARE PHYSICIAN _____ LOCATION/PHONE _____

REFERRING DOCTOR _____ LOCATION/PHONE _____

I understand that eye drops may be used to temporarily dilate my pupils and that these drops are necessary for my examination. I understand that I am financially responsible for payment of all charges at the time of each appointment, including insurance deductibles and co-payments, and that my insurance may not cover certain medical charges. I agree, in the event of non-payment, to bear the cost of collection and/or court cost and reasonable fees, should this be required. I understand it is my responsibility to advise Bethesda Retina/Dr. S. M. Sastry of any change in insurance coverage prior to being treated; failure to do so may result in insurance rejection. I authorize payment of medical benefits to Bethesda Retina/Dr. S. M. Sastry for professional services rendered. I authorize the release of medical information necessary to process any claims. A copy of this authorization can be used in lieu of the original. We value your privacy. We follow HIPPA guidelines and have a privacy policy posted in our office for your review.

Patients and/or accompanying individuals are prohibited from using any audio, video, wearables, or computer recording devices (digital or non-digital) in our office or exam rooms.

SIGNATURE _____ **DATE** _____

LOCAL PHARMACY NAME & LOCATION _____

BETHESDA RETINA, LLC | Dr. S. M. Sastry

PATIENT HISTORY RECORD

PATIENT NAME:	**DATE:**
DATE OF BIRTH:	**SEX:**

Please answer the following questions about your medical status and history:

Have you ever been treated for any medical conditions? (e.g. arthritis, diabetes, hypertension, etc.)
Yes ☐ No ☐ If YES, please explain: _____

Have you ever been treated for any eye disease? (e.g. cataract, glaucoma, retinal detachment, etc.)
Yes ☐ No ☐ If YES, please explain: _____

Have you ever had any surgery?
Yes ☐ No ☐ If YES, please provide details: _____

Have you ever been hospitalized?
Yes ☐ No ☐ If YES, please provide details: _____

Do you take any medications?
Yes ☐ No ☐ If YES, please list: _____

Do you take any EYE medications?
Yes ☐ No ☐ If YES, please list: _____

Do you have any drug or food allergies?
Yes ☐ No ☐ If YES, please list: _____

Review of Systems - Do you have any of the following:

	YES	NO	If YES, please explain:
General (e.g. chronic fever, fatigue, unexpected weight loss/gain) ……..…..…	☐	☐	_____
Ear/nose/throat problems (e.g. hearing loss, sinus issues, sore throat) …	☐	☐	_____
Heart problems (e.g. chest pain, irregular heartbeat) ……	☐	☐	_____
Respiratory problems (e.g. cough, shortness of breath, wheezing) ……..	☐	☐	_____
Gastrointestinal problems (e.g. diarrhea, heartburn, vomiting) ……..……	☐	☐	_____
Urinary problems (e.g. blood in urine, frequency, pain/discomfort) ……	☐	☐	_____
Skin problems (e.g. excessive dryness, rashes) ……	☐	☐	_____
Musculoskeletal problems (e.g. muscle aches, painful or swollen joints)	☐	☐	_____
Neurological problems (e.g. headaches, paralysis, numbness, weakness)	☐	☐	_____
Psychiatric problems (e.g. anxiety, depression) ……..….	☐	☐	_____

Do any medical or eye diseases run in your family? (e.g. cancer, diabetes, glaucoma, hypertension, macular degeneration, etc.)
Yes ☐ No ☐ If YES, please explain: _____

Do you smoke? Yes ☐ No ☐ If YES, how much? _____ **Drink alcohol?** Yes ☐ No ☐ If YES, how much? _____

Are you employed? Yes ☐ No ☐ If YES, how many hours per week do you work? _____

Does your job contribute to stress in your life? Yes ☐ No ☐

_____

DOCTOR'S SIGNATURE **DATE**

MEDICATION LIST

for

_____

NAME

_____ _____

TODAY'S DATE **BIRTHDATE**

MEDICATION NAME	DOSAGE	FREQUENCY