Retina Consultants, Ltd.

Michael J. Shapiro, MD
John M Galasso, MD, PhD
Charles M. Vygantas, MD
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Michael P. Blair,
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Jose M. Garcia-Gonzalez, MD
Michael Paxhia, MD

Phone (847)299-0700
Fax (847)390-0616
2454 E. Dempster St., Suite 400, Des Plaines, IL
3100 Ogden Ave., Lisle, IL 60532
755 S. Milwaukee Ave., Suite 101, Libertyville, IL 60048
2250 Point Blvd., Suite 120, Elgin, IL 60123
7667 W. 95th St. Suite 103, Hickory Hills, Il. 60457

Welcome! Please print in the appropriate fields below regarding your information. If you do not know the requested information, please remember to bring that information with you upon your next visit.

NEW PATIENT FORM: Please fill in the information

Patient Name:	Date of Birth: / /	Primary Phone Number: ( )

Social Security Number:	Sex: M F	Marital Status:	Cell Phone Number: ( )

Email Address	Work Phone Number: ( )

Street Address:	Preferred Language:
City:	Race:
State, Zip Code:	Ethnicity:

Insurance Information: Please fill in the information below.

PRIMARY Insurance

Primary Insurance Company:	**Insurance Holder's Name:**	**Ins. Holder's Date of Birth:**
Insurance Policy #:	**Insurance Group #:**	**Does this Insurance need a referral? If so, provide the referral #:**

SECONDARY Insurance

Secondary Insurance Company:	**Insurance Holder's Name:**	**Ins. Holder's Date of Birth:**
Insurance Policy #:	**Insurance Group #:**	**Does this Insurance need a referral? If so, provide the referral #:**

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Physician Contact:

Doctors: Who is the physician who referred you to Retina Consultants, Ltd?

Name:	Address:		Phone #:
	City:		Fax #:
	State:	Zip:	

Who is your primary care physician?

Name:	Address:		Phone #:
	City:		Fax #:
	State:	Zip:	

Other doctors who are treating you?

Name:	Address:		Phone #:
	City:		Fax #:
	State:	Zip:	

Name:	Address:		Phone #:
	City:		Fax #:
	State:	Zip:	

Emergency Contact Information: Someone we can contact in case of an emergency.

Name:	Address:		Phone #:
	City:		Relation:
	State:	Zip:	

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Basic Medical History:

Please fill in the appropriate fields below.

Allergies: Please list any drug, food, or other allergies below.

Allergy:	Reaction:
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Medications: Please list any medications you are currently taking below.

Eye medications:	Other Medications:
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Past Bodily Surgeries and Procedures: Please list any past surgeries below.

Surgery/Procedure:	Performed by (doctor):	Date of Surgery/Procedure:
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

Birth History: Please indicate your birth history below.

Birth duration and weight:

_____ _____lbs. _____ oz.

Any unusual circumstances? (premature, alcohol ingestion, oxygen therapy, birth trauma, etc.):

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Medical History: Please list any conditions, when they were diagnosed, and if they are controlled.

Example: Type II Diabetes, diagnosed 1990, controlled with medication

Condition, diagnosed/onset, mitigating factors:

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

Family History: Please list if anyone in your family has had the following conditions:

Amblyopia_____
Blindness: _____
Cataracts: _____
Crossed eyes: _____
Diabetic retinopathy: _____
Glaucoma: _____
Macular degeneration:_____
Retinal detachment: _____
Cancer: _____
Diabetes: _____
Heart disease: _____
High blood pressure: _____
Stroke: _____
Other:_____

Social History: Please answer the following questions below regarding your social history.

Do you smoke? Y N

Do you consume alcohol? Y N

What is your occupation?

_____

Do you have any restrictions while driving? If so, please list below:

1. _____
2. _____
3. _____

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Review of Systems: Please list if you are currently dealing with any of these symptoms, chronic or otherwise:

Constitutional Example: fevers, weight loss, etc.	No	Yes: _____
Eyes Ex: blurred vision, floaters, etc.	No	Yes: _____
Ear/nose/throat Ex: hearing or sinus problems, etc.	No	Yes: _____
Cardiovascular Ex: chest pain, irregular heartbeat, etc.	No	Yes: _____
Respiratory Ex: shortness of breath, wheezing, etc.	No	Yes: _____
Gastrointestinal Ex: abdominal pain, nausea, etc.	No	Yes: _____
Genitourinary Ex: blood in urine, discomfort, etc.	No	Yes: _____
Musculoskeletal Ex: joint pain, low back pain, etc.	No	Yes: _____
Integumentary skin/breast Ex: rashes, skin tumor, etc.	No	Yes: _____
Neurological Ex: numbness, weakness, etc.	No	Yes: _____
Psychiatric Ex: anxiety, depression, etc.	No	Yes: _____
Endocrine Ex: heat intolerance, thyroid problems, etc.	No	Yes: _____
Hematologic/lymphatic Ex: anemia, unusual bleeding, etc.	No	Yes: _____
Allergic/immunologic Ex: hives, seasonal allergies, etc.	No	Yes: _____

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Today: Please fill out the following information regarding your visit today if applicable.

What is the main REASON for your visit today?

Examples: Blurry vision in the right eye, poor vision in both eyes, dark spot in left eye, flashes of light, etc.

When did it start?

Examples: Started yesterday morning, started after skating accident, began late last night, began 3 years ago, etc.

Has it worsened or gotten better since then, gradually? Immediately? Why?

Examples: Suddenly worsened because of movement, gradually improves as day goes on, occasionally worsens throughout week, etc.

What affects the visual problem?

Examples: Worse at night, more floaters when head is shaken, better vision with more light, flashes of light show up when moving from light to dark room, etc.

Do you have any pain associated with the visual problem?

Examples: Sharp pain on sides of eyes, pain rated 3 of10, pulsing pain in the morning, etc.

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Authorization to Inform and Bill Insurance, Responsibility of Payment

I hereby authorize Retina Consultants, Ltd. to furnish information to insurance carriers and I authorize insurance benefits to be made to myself or on my behalf to Retina Consultants, Ltd for services rendered to my dependents or me. All professional services rendered are changed to the patient. Necessary forms will be completed to help expedite insurance carrier benefits. However the patient is responsible for all fees regardless of insurance coverage.

I further understand that insurance coverage does not guarantee payment of services and that the patient/guardian/caregiver is responsible for payment of all fees owed to Retina Consultants, Ltd. non-payment for services rendered will result in discontinuation of services.

X _____ _____

Signature of Patient or Legal Guardian | Date

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Retina Consultants, Ltd. may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Retina Consultants, Ltd.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review and have been notified of the Notice of Privacy Practices prior to signing this consent.

Retina Consultants, Ltd. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Retina Consultants, Ltd. Privacy Officer at

Retina Consultants, Ltd.
2454 E. Dempster St., Ste.
400, Des Plaines, IL 60016.

With my consent, Retina Consultants, Ltd. may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Retina Consultants, Ltd. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Retina Consultants Ltd. may email my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Retina Consultants, Ltd. restrict how it discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions but, if it does, it is bound by this agreement.

By signing this form, I am consenting to Retina Consultants, Ltd.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Retina Consultants, Ltd. may decline to provide treatment to me.

X _____ _____

Signature of Patient or Legal Guardian | Date

_____ _____

Patient's Name | Please print name of Legal Guardian if applicable