



MACULA VITREOUS RETINA  
PHYSICIANS & SURGEONS

Patient Name: \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ MM/DD/YYYY \_\_\_\_\_

Sex:  M  F Cell ☎: (xxx) xxx-xxxx Home ☎: (xxx) xxx-xxxx

Profession: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_

Home Address: \_\_\_\_\_ STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ COUNTRY \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ FIRST & LAST NAME, RELATIONSHIP \_\_\_\_\_ Cell ☎: (xxx) xxx-xxxx

Referring Provider: \_\_\_\_\_ FIRST & LAST NAME \_\_\_\_\_ Office ☎: (xxx) xxx-xxxx

Primary Care Physician: \_\_\_\_\_ FIRST & LAST NAME \_\_\_\_\_ Office ☎: (xxx) xxx-xxxx

Pharmacy: \_\_\_\_\_ NAME \_\_\_\_\_, \_\_\_\_\_ ADDRESS \_\_\_\_\_ Pharmacy ☎: (xxx) xxx-xxxx

### Past Medical & Surgical History:

Diabetes Years, last Hemoglobin A1c

Hypertension (high blood pressure)

Dyslipidemia (high cholesterol)

Epilepsy

Renal Failure On Dialysis? Dialysis Days?

Other \_\_\_\_\_

Heart Failure

Arthritis Rheumatoid or other?

Cancer Type, Year of Diagnosis

Heart attack Year, Treatment

Stroke Year, Treatment

Previous Surgery \_\_\_\_\_

### Past Ocular History:

Eye conditions and eye surgeries (e.g. cataract, glaucoma, macular degeneration, uveitis, etc) \_\_\_\_\_

### Medications:

Name of Medication, Dose, Frequency

### Allergies:

Medication or allergen, type of reaction

Medication or allergen, type of reaction

Medication or allergen, type of reaction

### Smoking History:

Never Smoked

Current Smoker How much do you smoke?

Former Smoker Quit Date, how long did you smoke for?



**AUTHORIZATION TO ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY**

I assign and authorize payments to Macula Vitreous Retina Physicians & Surgeons, PA. I understand my insurance company may not approve and reimburse my medical services in full, due to unusual and customary rates, benefits exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, or policy deductibles and co-insurance except where my liability is limited by contract of State or Federal Law. A copy of this authorization is considered the same as the original document.

**GENERAL CONSENT TO OBTAIN MEDICAL SERVICES**

I hereby voluntarily give my consent for Macula Vitreous Retina Physicians & Surgeons, PA to provide medical services to me or a minor child for whom I am legally responsible.

**AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

This is a summary of our Notice of Privacy Practices. The entire text detailing our privacy practices is available for your review, and we encourage you to read it and ask any questions you may have regarding our privacy practices. If you have any questions or would like to exercise any of your rights, please contact our Privacy Officer. After reviewing the materials, please sign in the spaces provided below.

**Patient Rights**

As a patient, you have a right to inspect, copy, amend, request a restriction on the use and disclosure of your Protected Health Information (PHI). You may request a copy of any accounting of disclosures, which will detail all disclosures made for reasons other than treatment, payment, or health care operational purposes. You may request that we communicate with you only in a specific manner (i.e. “only communicate with me at my work phone number.”)

**Provider Rights**

As your health care provider, we can use or disclose your PHI for treatment, payment, or health care operational purposes. Any other disclosures require you to sign a specific authorization.

**PATIENT CONTACT AUTHORIZATION**

In general, the HIPAA privacy policy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual’s office instead of the individual’s home.

I wish to be contacted in the following manner (check all that apply):

	May Leave A Detailed Message	May Leave Call Back Number Only
Cell ☐		
Home ☐		

Person(s) that you wish us to discuss your medical details with: \_\_\_\_\_

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. To assist us with this requirement, our office will only release information with a written request signed by the patient or legal guardian of said patient. This includes requests made by other physicians and their office(s). Our office will supply the proper form. **Note: Uses and disclosures for PHI may be permitted without prior consent in an emergency. All authorizations will be in effect until revoked in writing by the patient.**

Patient (or Guardian) Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_