



**Retina Consultant:** *Specializing in diseases and injuries of the retina, vitreous and macula*  
**of Carolina**

Date: \_\_\_\_\_

Account # \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
First MI Last

Address: \_\_\_\_\_  
Street City State ZIP

Sex: M or F Home Phone: \_\_\_\_\_ Daytime Number: \_\_\_\_\_ Cell: \_\_\_\_\_

Social Sec. # \_\_\_\_\_ Marital Status: S M D W Have you been to our practice before? Yes or No  
 Last Date Seen: \_\_\_\_\_

**Spouse or Guarantor Information**

Name: _____	Date of Birth: _____	SSN: _____
Address: _____		
Employer: _____	Phone: _____	

Patient Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Employment Status: Full Time or Part Time Referring Physician: \_\_\_\_\_

Race: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_  
Name: Relationship: Phone:

Language Spoken: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

**Primary Insurance Information**

Primary Insurance Name: \_\_\_\_\_

ID Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Group Number: \_\_\_\_\_

Address of Insurance Co: \_\_\_\_\_

Group Name: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**Secondary Insurance Information**

Secondary Insurance Name: \_\_\_\_\_

ID Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Group Number: \_\_\_\_\_

Address of Insurance Co: \_\_\_\_\_

Group Name: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**Is your visit related to Workman's Compensation or a Work Related Injury?** Yes or No

Date of Injury: \_\_\_\_\_ Location of Injury: Right Eye or Left Eye

Employer Contact Name: \_\_\_\_\_

Employer Contact Phone: \_\_\_\_\_

Registered By:

\_\_\_\_\_



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## **Financial/Payment Policy**

### **Please read the following regarding our payment policy:**

It is the policy of Retina Consultants of Carolina that the patient has the ultimate responsibility for payment on his or her account. Payment in full is due and required at the time of service.

**Insurance** - In an effort to accommodate the needs of our patients, we have contracted with Medicare and various insurance carriers. The specifics of your plan that govern how claims are paid are outlined in the policy booklet you received when you joined the insurance plan you elected. It is your responsibility to read and understand your insurance plan's provisions and requirements. If we are not contracted with your current insurance it will be necessary for you to pay in full for your visit at the time of service. We will provide you with an itemized receipt to file with your insurance company for them to reimburse you.

**If your insurance plan requires a referral/Authorization** from your primary care physician (PCP) it is your responsibility to make sure that the referral is in our office at the time of your visit or if no referral is obtained you may be required to reschedule your appointment. If we do not have a current referral, be prepared to pay for the visit in full or to reschedule your appointment.

**If your insurance plan required specialist co-pay**, that co-pay is due at every visit and is not an option. If you cannot pay your co-pay, be prepared to reschedule your appointment. It is also a requirement that cost not covered by insurance, coinsurance and deductibles be paid at the time of service.

**If you do not have your insurance card with you** at the time of your visit, be prepared to pay in full for the visit, or to reschedule your appointment. If you need assistance or have questions about your insurance card or our policies, please contact our Billing Office at (864) 233-5722 or 800-530-0788 PRIOR to your appointment.

**Self Pay Patients are required to pay a \$100** deposit at each visit. The remaining balance will be due at checkout of each visit.

**Retina Consultants of Carolina offers three payment plans** to assist our patients. These will be discussed as necessary and are only for balances that meet requirements.

\*If your account becomes delinquent for noncompliance to our financial policy, and we feel it is necessary to involve a third party in the collection effort, we reserve the right to add a collection fee to your balance. A list of charges will be furnished upon request. \*

### **I have read, understand and agree to Retina Consultants of Carolinas financial/payment policy.**

I understand that charges not covered by my insurance company, as well as applicable co-payment, deductible and out-of-network fees are my responsibility. In the event my account becomes delinquent I understand and agree to pay the collection fees and or attorney fees associated with the collection process. Failure to follow our policy may result in discharge from our practice. Retina Consultants will not deny emergency care

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Patient (Parent or Legal Guardian if a Minor):** \_\_\_\_\_



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**Release of Information Authorization  
Consent to/for Treatment  
Privacy Policy Acknowledgement  
Release of Health Information  
Appointments**

**Authorization to Release Information**

I authorize the release of medical information and the records concerning my treatment to Medicare, Medgap and/or other insurance companies and assign my claim for medical benefits to Retina Consultants to the extent permitted under applicable law or insurance agreements. I agree to allow Retina Consultants to request or release my information from or to other physicians or medical institutions as it deems necessary for my medical care and I further authorize the release of my medical records by such parties for such purpose. I agree to allow Retina Consultants to use my medical information and photography anonymously for the purpose of teaching or publication.

**Consent to Treatment**

I authorize the physician of Retina Consultants, their associates, technical assistants and other health care providers under their direction to provide diagnostic evaluations and treatment. I agree to papillary dilation for the purpose of examination and have been advised not to drive. I understand that no guarantee has or will be made to me regarding any my possible result or cure based on my examinations, and/or treatment.

**Release of Health Information**

I authorize the person(s)/parties listed in the box below to receive all health information about appointments, treatment, payment information, and/or other information regarding my healthcare until I sign a new form voiding this form.

Name: _____	Date of Birth: _____
Name: _____	Date of Birth: _____

**Notice of Privacy**

I have been given the opportunity to read in full the Privacy Notice provided by Retina Consultants of Carolina. I release Retina Consultants for all legal responsibility or liability that may arise from the above authorizations and agreements.

**Appointments**

Retina Consultants of Carolina strives to provide our patients with the best care possible but are unable to render that care if appointments are missed or not scheduled according to your physicians' recommendation. Please be advised that failure to show for appointments or neglecting to schedule or reschedule an appointment can result in discharge from this practice.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Signature of Patient or Legal Guardian (relationship to patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date



**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Eye Doctor: \_\_\_\_\_ Address: \_\_\_\_\_

Date Last Seen: \_\_\_\_\_ Next Appointment: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_ Address: \_\_\_\_\_

Date Last Seen: \_\_\_\_\_ Next Appointment: \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

**History of Present Illness**

What is the Main Problem that brings you here?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

In Which eye? \_\_\_\_\_ For How Long? \_\_\_\_\_

**Ocular History**

Did any previous eye disorder result in vision loss? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please describe:

\_\_\_\_\_  
 \_\_\_\_\_

Have you had any eye diseases, surgery or injury? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please describe:

\_\_\_\_\_  
 \_\_\_\_\_

Do you wear glasses or contacts? No \_\_\_\_\_ Yes \_\_\_\_\_

How old is your prescription?

\_\_\_\_\_  
 \_\_\_\_\_

Any history of Amblyopia or "Lazy Eye"? No \_\_\_\_\_ Yes \_\_\_\_\_

**Past History**

Have you had any serious medical problems? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please describe

\_\_\_\_\_  
 \_\_\_\_\_

Were you born premature? No \_\_\_\_\_ Yes \_\_\_\_\_

Have you ever been hospitalized for any reason? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please describe:

\_\_\_\_\_  
 \_\_\_\_\_

Do you take aspirin or blood thinner on a regular basis? No \_\_\_\_\_ Yes \_\_\_\_\_

Have you had any major surgery? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please describe:

\_\_\_\_\_  
 \_\_\_\_\_



**Review of Symptoms**

Please check any symptom or problem that is Chronic or Persistent. Circle NONE if nothing in the category applies.

**Constitutional:** **NONE**

- Fever
- Weight Loss
- Night Sweats

**Ear, Nose, Mouth, Throat:** **NONE**

- Hearing Loss
- Pain/Discharge
- Dizziness/Fainting
- Nose Bleeds
- Ringing in Ears
- Sinus Pain

**Cardiovascular:** **NONE**

- Chest Pain
- Irregular Heart Beat
- Shortness of Breath on Exertion
- Swelling of Feet
- High Blood Pressure
- Heart Attack/Disease
- Elevated Cholesterol or Triglycerides

**Respiratory:** **NONE**

- Shortness of Breath
- Cough
- Asthma/Emphysema
- Tuberculosis (T.B.)
- Other

**Gastrointestinal:** **NONE**

- Change in Bowel Habits
- Diarrhea
- Constipation
- Stomach Pain
- Ulcers
- Other

**Endocrine:** **NONE**

- Thyroid Disease
- Diabetes

**Musculoskeletal:** **NONE**

- Pain/Swelling
- Weakness
- Lupus
- Arthritis

**Skin/Breast:** **NONE**

- Masses
- Tumors
- Rash
- Other

**Neurologic:** **NONE**

- Numbness/Tingling
- Seizures/Epilepsy
- Weakness in Arm/Leg
- Lyme Disease
- Alzheimer's Disease
- Parkinson's Disease
- Migraines
- Stroke

**Mood Disorders:** **NONE**

- Anxious/Nervous
- Depression
- Other

**Genitourinary:** **NONE**

- Kidney Trouble
- Urinary Problems
- Venereal Disease

**Hematologic:** **NONE**

- Bleed/Bruise Easily
- Anemia
- Prior Blood Transfusion
- Sickle Cell Disease
- HIV+ /AIDS and/or Exposure
- Hepatitis

**Diabetics:**

How long have you had diabetes? \_\_\_\_\_ How often do you see your diabetic doctor? \_\_\_\_\_  
 How often do you test your blood sugar? \_\_\_\_\_  
 What was your blood sugar when last tested? \_\_\_\_\_ Your last Hemoglobin A1C \_\_\_\_\_  
 Have you ever had an Insulin Reaction? \_\_\_\_\_ Date of last reaction: \_\_\_\_\_



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

**Social History**

		YES	NO		YES	NO
Do you:	Drink Alcohol	_____	_____	Use Illegal Drugs	_____	_____
	Smoke	_____	_____	Live Alone	_____	_____
	Chew Tobacco	_____	_____	Exercise	_____	_____

What was your occupation? \_\_\_\_\_

What is your highest level of education completed? \_\_\_\_\_

Are you currently pregnant? No \_\_\_\_\_ Yes \_\_\_\_\_

**Family History**

Any significant eye diseases or other diseases which run in your family?

\_\_\_\_\_  
 \_\_\_\_\_

**Medication**

Please list all medications including eye drops which you are currently taking.

	Name of Drug	Dosage	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

**Allergies**

Do you have allergies to medications?

No \_\_\_\_\_ Yes \_\_\_\_\_

	Medication	Reaction
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Do you have reaction problems with local or general anesthesia? No \_\_\_\_\_ Yes \_\_\_\_\_

Type of Reaction? \_\_\_\_\_

Any other allergic reactions: \_\_\_\_\_

Please Explain:

\_\_\_\_\_  
 \_\_\_\_\_