MONMOUTH RETINA

RUPAN TRIKHA, M.D.

MARTIN URAM, M.D., M.P.H.

CHIRAG V. PATEL, M.D.

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE/MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF, RUPAN TRIKHA, M.D. FOR ANY SERVICES FURNISHED TO ME BY THAT PHYSICIAN OR SUPPLIER. I GIVE AUTHORIZATION TO ANY HOLDER OR MEDICAL INFORMATION CONCERNING ME TO RELEASE INFORMATION NEEDED TO DETERMINE THE BENEFITS PAYABLE FOR RELATED SERVICES TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS.

INSURANCE/MEDICARE WILL ONLY PAY FOR SERVICE THAT IT CONSIDERS TO BE MEDICALLY "REASONABLE AND NECESSARY." IF INSURANCE/MEDICARE DETERMINES THAT A PARTICULAR SERVICE, ALTHOUGH OTHERWISE COVERED, IS NOT "REASONABLE AND NECESSARY" UNDER ITS STANDARDS IT WILL DENY PAYMENT FOR THAT SERVICE. I WISH TO HAVE SERVICES PROVIDED BY RUPAN TRIKHA, M.D., MARTIN URAM, M.D., OR CHIRAG V. PATEL, M.D., THEREFORE I AGREE THAT, IF INSURANCE/MEDICARE DENIES PAYMENT FOR THESE SERVICES I SHALL REMAIN PERSONALLY RESPONSIBLE FOR ANY BALANCE DUE.

I UNDERSTAND THAT MY PUPILS WILL BE DILATED AND MY VISION WILL BE BLURRY AFTERWARDS, THEREFORE I MAY BE UNABLE TO DRIVE.

I UNDERSTAND THAT IF MEDICALLY NECESSARY FOR A DIAGNOSIS, TESTING, SUCH AS FLUORESCEIN ANGIOGRAM, ULTRASOUND, VISUAL FIELD EVALUATION, AND OTHER OPTIC NERVE AND RETINAL EVALUATIONS MAY BE PERFORMED WITH MY INFORMED CONSENT.

AFTER MY DOCTOR REVIEWS THE RISKS AND BENEFITS OF ANY NECESSARY PROCEDURES WITH ME DURING MY CONSULTATION, I GIVE PERMISSION FOR OPHTHALMIC LASER TREATMENTS, CRYOTHERAPY, INTRAVITREAL INJECTIONS OF DYES AND MEDICATIONS AND/OR INTRAOCULAR INJECTIONS OF MEDICATIONS AND GASES.

I UNDERSTAND THAT A FACILTY FEE FOR THE **RETINA CONSULTANTS SURGERY CENTER** WILL BE CHARGED TO MY INSURANCE IF I UNDERGO LASER EYE SURGERY.

I AM AWARE THAT I AM RESPONSIBLE FOR ANY OUTSTANDING BALANCE NOT PAID BY MY INSURANCE COMPANY.

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I WAS OFFERED THE **NOTICE OF PRIVACY PRACTICES** FOR THE PRACTICE OF RUPAN TRIKHA, M.D., MONMOUTH RETINA TO READ, AND IF I CHOOSE TO KEEP AND TAKE WITH ME.

PRINT NAME: _____ **DATE:** _____

SIGNATURE: _____

MONMOUTH RETINA

PATIENT INFORMATION

Name:_____ Preferred Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Preferred Contact: **CHECK ONE** Email:_____

☐ Home #_____ ☐ Cell #_____ ☐ Work#_____

Sex: ☐ M ☐ F Age:_____ Date of Birth:_____ Social Security #_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Emergency Contact:_____ Relation to Patient_____ Phone #_____

Do we have permission to discuss care with this person? ☐ Yes ☐ No

****IF PATIENT IS A MINOR, PLEASE COMPLETE THE NEXT SECTION****

Name:_____ Preferred Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

☐ Home #_____ ☐ Cell #_____ ☐ Work #_____

Sex: ☐ M ☐ F Age:_____ Date of Birth:_____ Relation to Patient:_____

PRIMARY CARE PHYSICIAN

First Name:_____ Last Name:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone #_____ Fax #_____

PHARMACY

Pharmacy Name:_____

Location:_____ Phone #_____

INSURANCE

Primary:	Secondary:
_____	_____
Subscriber Name (Policy Holder)	Subscriber Name (Policy Holder)
_____	_____
Date of Birth:_____	Date of Birth:_____
Relation to Patient:_____	Relation to Patient:_____

MONMOUTH RETINA

Race (check one)		Ethnicity (check one)	Language (check one)	
☐ American Indian	☐ Asian	☐ Hispanic/Latino	☐ English	☐ Italian
☐ Alaska Native	☐ Latin American	☐ Non-Hispanic or Latino	☐ French	☐ Portuguese
☐ African American	☐ White	☐ Declined to Specify	☐ German	☐ Spanish
☐ Declined to Specify			☐ Declined to Specify	

REFERRAL INFORMATION

Reason for visit?_____

Who referred you to our office? ☐ Doctor ☐ Patient ☐ Other:_____

Referring Doctor: _____

Address:_____ City:_____State:_____ Zip Code_____

MEDICAL HISTORY

Y/N	**Type I or Type II** Diabetes	**Y/N**	**HYPER / HYPO** Thyroid
Y/N	Insulin Dependent	**Y/N**	Dementia / Alzheimer's
Y/N	Hypertension	**Y/N**	HIV / AIDS
Y/N	Cholesterol	**Y/N**	Hepatitis: **A B C**
Y/N	Heart Disease / A-Fib	**Y/N**	Depression / Anxiety
Y/N	Arthritis	**Y/N**	Cancer:
Y/N	Asthma / COPD	**Y/N**	Tumor:
Y/N	Kidney Disease	**Y/N**	Stomach (Ulcers)
Y/N	Stroke	**Other:**	

SURGICAL HISTORY: *UNRELATED* to any eye surgery ☐ **NONE**

	DATE

EYE SURGERIES / TRAUMA ☐ **NONE**

	DATE

MONMOUTH RETINA

MEDICATIONS you are currently taking? ☐ **NONE**

EYE DROPS you are currently taking? ☐ **NONE**

Are you allergic to any **MEDICATION** or **ALLERGENS**? ☐ **NONE**

FAMILY HISTORY (IMMEDIATE FAMILY) *Check ALL that apply*

	MOTHER	FATHER	SISTER	BROTHER	GRANDMOTHER	GRANDFATHER	AUNT	UNCLE
DIABETES: **TYPE I / TYPE II**								
HYPERTENSION								
HEART DISEASE/A-FIB								
ARTHRITIS								
CANCER/TUMOR								
THYROID DISEASE								
GLAUCOMA								
MACULAR DEGENERATION								
RETINAL DETACHMENT								
BLINDNESS								
STROKE								
KIDNEY DISEASE								
HEADACHES/MIGRAINES								

MONMOUTH RETINA

SOCIAL HISTORY *Check which applies*

Do you Smoke? ☐ Current ☐ Former ☐ Never	**Marital Status?** ☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Separated	**Do you drink Alcohol?** ☐ Social ☐ Frequent ☐ Never	**Are you working?** ☐ Yes ☐ Retired ☐ No ☐ Student ☐ Disabled
Do you Drive? ☐ Yes ☐ No	**Do you live alone?** ☐ Yes ☐ Nursing Home ☐ With Family ☐ Retirement Center ☐ With Caretaker	**Did you receive your flu vaccination?** ☐ Yes ☐ No ☐ Never When? _____ **Did you receive your pneumonia vaccination?** ☐ Yes ☐ No ☐ Never When? _____	

REVIEW OF SYSTEMS *Check all that apply*

Cardiovascular
__ Chest Pain
__ Shortness of Breath
__ Swelling of Feet
__ Irregular Heart Beat
__ Blood Pressure Stable
__ Blood Pressure Uncontrolled
__ Unsure of Blood Pressure Control
__ No Chest Pain or Shortness of Breath
__ Negative

Constitutional
__ Fatigue
__ Fevers
__ Frequent Colds
__ Headaches
__ Incontinence
__ Unexplained Falls
__ Weight Gain
__ Loss of Appetite
__ Chills
__ Night Sweats
__ Negative

Endocrine
__ Excess Thirst
__ Excessive Urination
__ Heat Intolerance
__ Cold Intolerance

HENT
__ Hearing Loss
__ Sore Throat
__ Runny Nose
__ Dry Mouth
__ Jaw Claudication
__ Ear Ache
__ Negative

Integumentary
__ Rash
__ Change in Moles
__ Skin Sores
__ Skin Cancer
__ Severe Itching
__ Negative

Musculoskeletal
__ Muscle Aches
__ Joint Pain
__ Difficulty Laying Flat
__ Back Pain
__ Negative

Neurologic
__ Weakness
__ Headaches

MONMOUTH RETINA

Endocrine cont.
__ Hair Loss
__ Dry Skin
__ Blood Sugars Poorly Controlled
__ Blood Sugars Stable
__ Unsure of Blood Sugars
__ Negative

Gastrointestinal
__ Abdominal Pain
__ Nausea
__ Diarrhea
__ Bloody Stools
__ Stomach Ulcers
__ Constipation
__ Trouble Swallowing
__ Jaundice or Yellow Skin
__ Negative

Genitourinary
__ Pain/Burning on Urination
__ Blood in Urine
__ Bladder Trouble
__ Dialysis
__ Genital Sores or Ulcers
__ Kidney Failure
__ Kidney Problems
__ Kidney Stones
__ Prostatitis
__ Testicular Pain
__ Urinary Discharge
__ Negative

Hematology/Oncology
__ Easy Bruising
__ Prolonged Bleeding
__ Negative

Neurologic cont.
__ Scalp Tenderness
__ Dizziness
__ Paralysis of Extremities
__ Tremor
__ Stroke
__ Numbness
__ Tingling in Body
__ Seizures or Convulsions
__ Fainting
__ Negative

Psychiatric
__ ADHD
__ Bipolar Disorder
__ Depression
__ Negative

Respiratory
__ Wheezing
__ Cough
__ Coughing Up Blood
__ Severe or Frequent Colds
__ Difficulty Breathing
__ No Cough or Wheezing
__ Negative