Retina Center of Oklahoma **DEMOGRAPHIC INFORMATION** **Sam S. Dahr,MD**

PATIENT LAST NAME:_____ **FIRST NAME:** _____ **MI:**_____

MAILING ADDRESS: _____ **CITY:** _____

STATE: _____**ZIP:**_____ **EMAIL:** _____

HOME PHONE:_____**WORK PHONE:**_____ **CELL PHONE:**_____

MARITAL STATUS: Single Married Divorced Widowed Separated BIRTH DATE:_____ **SS#** _____

SEX: MALE FEMALE EMPLOYER NAME:_____ **PREFERRED LANGUAGE:** _____

RACE: (Please circle) American Indian, Alaskan Native, Asian, African American, Native Hawaiian or other Pacific Islander, Caucasian , Other

Declined to Specify **ETHNICITY: (Please circle)** Hispanic or Latino Not Hispanic or Latino Unknown Declined to Specify

PRIMARY CARE PROVIDER: _____ **ADDRESS:** _____

PHONE #_____ **REFERRING PROVIDER :** _____

EMERGENCY CONTACT:_____**RELATION:**_____**PHONE:**_____

RESPONSIBLE PARTY / GUARANTOR INFORMATION (IF DIFFERENT FROM PATIENT)

PATIENT'S RELATIONSHIP TO THE RESPONSIBLE PARTY:(circle one) SELF SPOUSE CHILD OTHER

RESP. PARTY LAST NAME:_____ **FIRST NAME:** _____ **MI:** _____

ADDRESS: _____

DATE OF BIRTH: _____ **SEX:** FEMALE MALE **HOME #:**_____ **WORK #**__ _____

CELL #:_____**EMPLOYER:** _____

INSURANCE INFORMATION

If copies of insurance cards are not obtained, please complete the following insurance information:

PRIMARY INS NAME: _____ _____ **POLICY HOLDER'S NAME:**_____

ADDRESS: _____

DATE OF BIRTH: _____ **SSN#** _____ **POLICY#** _____ **GROUP#** _____

SECONDARY INS NAME: _____**POLICY HOLDER'S NAME:**_____

ADDRESS: _____

DATE OF BIRTH: _____ **SSN#** _____ **POLICY#** _____ **GROUP #** _____

MY SIGNATURE BELOW CERTIFIES:

I understand that***, if necessary***, it is my responsibility to obtain any necessary referral or authorization from my insurance carrier.
I understand that my insurance plan may not cover the entire bill and that I will be financially responsible for any coinsurance, deductible, and non-covered service as determined by the insurance carrier.
I understand that ***if I do not have health insurance*** to cover this bill I will be financially responsible for any and all charges.
AUTHORIZATION TO FILE INSURANCE: I hereby authorize SAM DAHR, M.D., to release to Medicare or other insurance carrier or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. This authorization includes release of information concerning HIV testing, diagnosis or treatment of AIDS, AIDS related conditions, drug or alcohol abuse, drug related conditions, and/or psychiatric/psychological diagnosis/treatment. Also, I authorize and request Medicare or any other insurance carrier to pay directly to the above named physician the amount due to me in my pending claim for medical or surgical services.

SIGNATURE: _____ **DATE:** _____

MEDICAL INFORMATION **RETINA CENTER OF OKLAHOMA**

NAME:_____ **DATE**:_____

Please carefully complete this form. Thank You.

List all current medications and dosage, including herbs/supplements/over-counter medications

List all medical issues you have been diagnosed with and include date	**List all past surgeries and year performed**
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.

List all known allergies (Drug, food, or substance)
Do you have any pets, and if so what kind?

Patient's Signature_____ Date:_____

MEDICAL HISTORY QUESTIONAIRE **Retina Center of Oklahoma**

NAME_____ TODAY'S DATE_____

1. **THE MAIN REASON I MADE THIS APPOINTMENT IS:**

_____

_____

_____

2. **REVIEW OF SYSTEMS**
   Do you have any problems in the following areas? If "**YES**," please explain.

	YES	NO	EXPLANATION OF PROBLEM
Constitutional Symptoms			
Fever	☐	☐	_____
Weight Loss	☐	☐	_____
Eyes			
Loss of Vision	☐	☐	_____
Blurred Vision	☐	☐	_____
Bending of Straight Lines	☐	☐	_____
Blind Spots	☐	☐	_____
Loss of Side Vision	☐	☐	_____
Floaters	☐	☐	_____
Flashes of Light	☐	☐	_____
Double Vision	☐	☐	_____
Red Eye	☐	☐	_____
Light Sensitivity	☐	☐	_____
Eye Pain or Soreness	☐	☐	_____
Ears, Nose, Mouth, Throat			
Sinus Congestion	☐	☐	_____
Dry Throat/Mouth	☐	☐	_____
Ulcers in or around Mouth	☐	☐	_____
Hearing Loss	☐	☐	_____
Cold sores	☐	☐	_____
Cardiovascular			
High blood pressure	☐	☐	_____
Circulation problems	☐	☐	_____
Cholesterol treatment	☐	☐	_____
Respiratory			
Asthma	☐	☐	_____
Emphysema	☐	☐	_____
Sleep apnea	☐	☐	_____
Smoked more than 20 years	☐	☐	_____

2. Review of Systems (Continued)
Do you have any problems in the following areas? If "**YES,**" please explain.

Genitourinary	**Yes**	**No**	
Genital Ulcers	☐	☐	_____
Blood in Urine	☐	☐	_____
Musculoskeletal			
Arthritis	☐	☐	_____
Jaw Pain when Chewing/Talking	☐	☐	_____
Ankle Swelling	☐	☐	_____
Integument			
Scalp Pain when Combing/Brushing	☐	☐	_____
Skin Rashes	☐	☐	_____
Tick Bites	☐	☐	_____
Loss of Skin Pigment	☐	☐	_____
Neurological			
Migraines	☐	☐	_____
Frequent Headaches	☐	☐	_____
Seizures	☐	☐	_____
Loss of Strength (Paralysis)	☐	☐	_____
Numbness in Hands or Feet	☐	☐	_____
Endocrine			
Growth (Mass) in Neck or Throat	☐	☐	_____
High blood sugars/diabetes	☐	☐	_____
Hematological/Lymphatics			
Swollen Glands	☐	☐	_____
Easy Bruising	☐	☐	_____
Prolonged Bleeding	☐	☐	_____
Are you on a blood thinner?	☐	☐	_____
History of blood clot	☐	☐	_____

Any other issues going on elsewhere in your body, even if they seem unlikely to be related to your eyes?

☐ ☐ _____

Patient's Signature_____ Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

I understand that, as part of my health care, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and plans for future care or treatment. I understand that this information serves as:

- A basis for my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and/or surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A means by which we carry out our health care operations.
- Appointment reminders or notifications.

I understand that I have been provided with opportunity to review a "NOTICE OF PRIVACY PRACTICES" that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the practice reserves the right to change our notice and practices. I understand that I have the right to request restrictions as to how my health care information may be used or disclosed to carry out treatment or to arrange payment. I understand that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

I understand that if I do not consent, you cannot provide services to me.

Oklahoma law requires that we advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). It may also include mental health or other sensitive information.

Signature:_____ Date:_____
(of patient or legal representative)

Capacity of legal representative:_____

STAFF ONLY: *If patient did not or could not acknowledge, please indicate why:*

INFORMED CONSENT FOR DILATED EYE EXAM/S AND CONSENT FOR FLUORESCEIN ANGIOGRAM/S

INFORMATION REGARDING DILATING EYE DROPS

1. Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

2. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

3. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

4. I have read the above and understand and all my questions, if any have been answered to my satisfaction regarding dilation. I hereby authorize Dr. Dahr and/or assistant(s) to administer dilating eye drops. The eye drops are necessary to diagnose and/or treat my condition. This consent will be valid until I revoke it.

_____ _____

Patient's Signature Date

INFORMATION REGARDING DILATING FLUORESCEIN ANGIOGRAPHY

INDICATIONS AND ADMINISTRATION

5. Angiography is a diagnostic procedure in which a rapid sequence of photographs is taken to document the blood circulation of the retina/choroid. The dye is usually injected into a vein in the arm, forearm, or hand.

6. Since the fluorescein dye is a very bright yellow, the skin may appear jaundiced for a few hours and then the yellow color disappears. The dye is excreted through the kidney causing the urine to be bright yellow for 24-36 hours.

POSSIBLE COMPLICATIONS

7. Documented adverse reactions to the dyes which can occur include: nausea, headache, upset stomach, vomiting, light-headedness, fainting, hives, and itching.

8. Even more rarely, severe allergic reactions (anaphylaxis) or bronchospasm can occur and be life threatening. I have informed my physician of any allergies to foods, iodine, or medications. **By signing this consent, I certify that I have informed my physician if I have asthma.**

9. The leakage of the fluorescein dye out of the blood vessel is painful and every effort is made to prevent this from occurring.

*** *This paragraph is **FOR WOMEN** only:****

10. Intravenous fluorescein is usually not administered to pregnant or nursing women, although there is no scientific evidence to suggest that it might harm the fetus or nursing babies.

By signing this consent, I certify to the best of my knowledge that I am NOT pregnant or nursing a baby.

11. I have read and understand the information about the Fluorescein Angiogram. All my questions, if any, have been answered to my satisfaction.

12. I hereby authorize and direct Dr. Dahr and/or assistants and/or their designees to provide such additional services as they may deem necessary and reasonable.

13. I understand that no guarantees of any kind regarding these procedures have been made to me.

14. I consent to the use of the above photographs and other materials for scientific purposes, provided my identity is not revealed by the pictures or the descriptive text accompanying them.

15. I hereby authorize Dr. Dahr and/or assistants to administer intravenous Fluorescein at intervals as needed for the purpose of performing angiography. This consent will be valid until I revoke it or my condition changes to the point that the risks and benefits of this medication for me are significantly different.

_____ _____

Patient's Signature Date