Regional Retinal Consultants

Gary J Miller, MD Vitreoretinal Specialist

Dear Patient:

Thank you for scheduling an appointment with Regional Retinal Consultants. We dedicate ourselves to enhancing the quality of life for every individual we treat by helping each see his or her best, and by preserving and protecting our patients' vision and eye health throughout life.

It is extremely helpful for us to know the reason for your visit and your medical history prior to your appointment with us. For this reason, we have enclosed questionnaires that we hope you will fill our as completely as possible and bring to your appointment.

Please bring the following information to your visit:

- Insurance Card
- Photo Identification
- Completed Registration Form
- Completed Patient History Form
- Completed Referral/Social/Allergy Form
- Completed Ophthalmic History Form

If you have any questions, a staff member will be happy to answer them for you. It is my pleasure to welcome you in advance of your first visit.

Sincerely,

G. James Miller, M.D.

1415 River Avenue, Suite A, Cumberland, MD 2150
301-876-9236

888 Memorial Drive, Suite 201, Oakland, MD 21550
301-334-1146

Patient Registration Form

PATIENT INFORMATION				
Patient Name: First Middle Last		Date of Birth:	Social Security Number: ________ - ________ - ________	
Home Address: Street (no post office box)		City	State	Zip
Home Phone: (______) ______ - _______	Sex: (circle one) M F	Marital Status: (circle one) Single/Married/Divorced/Widowed	E-mail Address:	
Employer Name:		Occupation	Employer Phone: (________) ________ - ________	
Employer Address: Street (no post office box please)		City	State	Zip
GUARANTOR INFORMATION (the person responsible for the patient's account; **complete only if different from patient**)				
Guarantor Name: First Middle Last		Date of Birth:	Social Security Number: ________ - ________ - ________	
Home Address: Street (no post office box)		City	State	Zip
Relationship to Patient: (circle one) Spouse/Parent/Legal Guardian/Legal Representative				
Employer Name:		Occupation	Employer Phone: (_______) ________ - ________	
Employer Address: Street (no post office box please)		City	State	Zip
FIRST INSURANCE		**Referral Required: _____ Yes _____ No**		
Insurance Name:			Insurance Phone: (_______) ________ - _______	
Insurance Address: Street		City	State	Zip
Policy Holder's Name:		Date of Birth:	Social Security Number: ________ - ________ - ________	
Policy ID Number:		Policy Group Number:	Policy Effective Date:	
SECOND INSURANCE		**Referral Required: _____ Yes _____ No**		
Insurance Name:			Insurance Phone: (_______) ________ - ________	
Insurance Address: Street		City	State	Zip
Policy Holder's Name:		Date of Birth:	Social Security Number: ________ - ________ - ________	
Policy ID Number:		Policy Group Number:	Policy Effective Date:	
THIRD INSURANCE		**Referral Required: _____ Yes _____ No**		
Insurance Name:			Insurance Phone: (_______) ________ - ________	
Insurance Address: Street		City	State	Zip
Policy Holder's Name:		Date of Birth:	Social Security Number: ________ - ________ - ________	
Policy ID Number:		Policy Group Number:	Policy Effective Date:	
EMERGENCY CONTACT				
Name:	Telephone:		Relationship:	

Is your visit due to a job related accident? _____ Yes _____No If yes, indicate the date of injury: ______/______/______
Please be sure to complete your employer information at the top of the page.

Would you be interested in having communications sent to you via your e-mail address?
Examples: appointment reminders, administrative updates and health bulletins? _____ Yes _____ No

How did you hear about our Practice? (circle one) Relative/Friend/Telephone Book/Web Site/Physician Referral/Other

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Patient History Form

Family Physician: ____

Ophthalmologist: ____

Optometrist: ____

- **Past Medical History:** *Surgeries/Illnesses/Medications/Allergies*

Surgeries:

Illnesses/Hospitalizations:

Medications:

- **Allergies:** *Please check the list below and write in any other allergies that you might have.*

	Y	N		Y	N		Y	N	Notations
Latex			Cipro (Fluoroquinolone)			Betadine/Iodine			
Tape			Genatmicin/Tobramycin			Seafood			
Penicillin			Keflex/Cephalosporin			Egg White			
Vancomycin			Anesthesia medications			Soybeans			
Other									

- **Social History:** *Please check all that apply.*

Lives with		Alcohol		Smoking	
Occupation		Drugs		Vitamins	
Occupation History					
Activities	❒ computer ❒ TV ❒ Driving ❒ Reading ❒ crafts/sewing ❒ Music				
	❒ hunting ❒ fishing ❒ skiing ❒ boating ❒ jogging ❒ exercising				
Other					

Patient Name ____ DOB ____________

Date of Update ______________ Tech _________ Doctor _______________

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- **Family History:**

Condition	Y	N	Who	Condition	Y	N	Who	Condition	Y	N	Who
Glaucoma				Crossed Eyes				Hypertension			
Cataract				Blindness				Tuberculosis			
Retinal Detachment								Stroke			
Degeneration				Diabetes				Anesthesia			

- **Review of Systems**: *Do you have any of the following problems? Check **N** for major groups (bolded) if there are no problems for that organ system or question and go to next category.*

	Y	N		Y	N		Y	N
Constitutional			**Genital - Urinary**			**Hematologic/lymphatic**		
Weight loss, fever, fatigue			Kidney failure/Dialysis			Anemia		
Head/Neck/Nose/Throat			Incontinence/Urgency			Blood thinners/bruise		
Sinus			Pregnancy			Coumadin		
Teeth			Prostate problems			ASA		
Throat problems			**Musculoskeletal**			Plavix		
Hearing impaired/Aids			Arthritis			Blood clots		
Pulmonary Disease			Mobility problems					
Coughing/Wheezing			Neck Problems			**Cancer**		
Asthma/Bronchitis			Extremity problem			Type of cancer?		
Oxygen dependent			Prosthesis					
Sleep apnea			**Skin**			**Allergic/Immunologic**		
Shortness of Breath			Eczema/Psorias			Autoimmune disease?		
Cardiac/Vascular			Rashes					
Congestive Heart Failure			Ulcers			**Specific meds ever used?**		
Chest pain			**Neurologic**			Flomax (Tamsulosin)		
Palpitations/Irreg beat			Vertigo; Dizziness			Uroxatral		
High Blood Pressure			Weak; Faint			Hytrin (Terazosin)		
High cholesterol			Seizures			Cardura (Doxazosin)		
Pace Maker/Defib			History Stroke/paralysis			**Anesthesia history**		
Shortness of Breath			Parkinsons			Problems in past?		
Exercise Intolerance			**Psych**			Family problems?		
Murmur			Claustrophobia			**Infections**		
Valve disease			Altzheimers/Dementia			Hepatitis		
Gastrointestinal			Depression			MRSA (Staph infection)		
Reflux, Nausea,			Panic Attacks			Tuberculosis		
Diarrhea, hiatal			**Endocrine**			HIV		
Problems swallowing			Diabetes			Other		
Liver/Cirrhosis/Jaundice			Thyroid					

Patient Name ____ DOB __________

Date of Update ___________ Tech _______ Doctor ____________

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Ophthalmic History Form ☐Initial ☐ Continuation Page_____

Ophthalmic Event: *Begin with historical information and initial encounter, include brief description-eye(s), medication reactions or changes, trauma, laser surgeries, surgeries, post-operative problems, glaucoma treatments or changes, general observations, referrals to or referring physician.*	**Approximate Date of Event:**

Patient Name ____ DOB _____________

Date of Update _______________ Tech _________ Doctor ________________

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Referral/Social/Allergy Form

- **Referring Doctor:** ____
- **Reason for Referral:** ____
- **Second Home Location/Months:** ________________________________
- **Social Update:** *Include change in spouse's health, change in social support, limitations, etc. with approximate dates.*

- **Ophthalmic Allergy List:**

Drug	**Date:** *(If Known)*	**Reaction**

Patient Name ____ DOB ___________

Date of Update ____________ Tech ________ Doctor _____________

Our Office Policy Regarding Patient Financial Responsibility

We are committed to providing you with the best possible medical care, regardless of whether or not you have health insurance. In order to achieve this goal, we need your assistance and your understanding of our financial policy.

Payment for services is due at the time services are rendered, unless we participate with your insurance. As a courtesy, we will bill participating provider insurance on the patient's behalf. Your co-pay, any deductible, or any amount not covered by your insurance is due at the time of your visit. The fees that we charge are within the usual range for our area and specialty.

If you have an insurance plan that requires a referral, you will need to contact your primary care physician and have them forward a referral to our office. We may not be able to see you if a referral is not on file with our office by the scheduled appointment date.

If we are not a participating provider with your insurance or if you do not have insurance, you will be expected to pay the entire fee, in full, at the time of the visit. If we do not participate with your insurance, we can provide you with information for you to submit to you insurance carrier.

Regional Retinal Consultants accepts the following payment options: cash, check, and debit cards: Visa, MasterCard and Discover. We will gladly discuss any questions you have regarding our billing and your insurance. Please call and speak with a receptionist if you have any questions regarding our policies.