

## WAGNER MACULA & RETINA CENTER

<p style="text-align: center; margin: 0;"><b>For Office Use Only:</b></p> <p>Referral Date: _____ First Appt Date _____ Time _____</p> <p>Contact Person _____ Physician: ALW / MDC / MKH    VB ORF KMK SSE SEP HRC CPK</p>	DX: _____
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### PATIENT INFORMATION

<b>Patient Name</b>			
<b>Street Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Phone #</b> <b>Alternate#</b>			
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			
<b>Soc Sec No</b>	<b>Date of Birth</b>	<b>Age</b>	<b>Sex</b>
<b>Employer</b>	<b>Address</b>	<b>City, State, Zip Code</b>	
<b>Work Phone</b>	<b>Occupation</b>	<b>Job Title</b>	

### Spouse Information

<b>Spouse Name</b>	<b>Employer</b>
<b>Spouse SS#</b>	<b>Address:</b>
	<b>Phone#:</b>

### EMERGENCY CONTACT

<b>Name</b>	<b>Relationship</b>	<b>Phone</b>
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<b>Referring Physician:</b>	<b>Medical Doctor</b>
<b>Phone#:</b>	<b>Address:</b>
	<b>Phone#:</b>

### INSURANCE INFORMATION

<b>Primary Insurance:</b>	<b>Secondary Insurance:</b>
<b>Group#:</b>	<b>Group#:</b>
<b>ID#:</b>	<b>ID#:</b>

### ASSIGNMENT RELEASE

I hereby authorize the release of medical information to my insurance company and agree that insurance benefits are to be paid directly to the physician. I understand that any insurance is a contract between me and the insurance company and that any filing on my behalf by the practice is done as a courtesy. I request that payment under Medicare Insurance Program be made on my behalf to the Retina and Vitreous Center, PC for any services furnished by that physician. I am financially responsible for all services. I agree to pay for all costs of collection, including an attorney's fee of 33 1/3% of the balance referred to the attorney in the event of default. (VB ORF KMK SSE SEP HRC CPK)

\_\_\_\_\_  
Patient or Responsible Party

\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY**  
**APPLY ALLERGY**  
**LABEL HERE**

# WAGNER

## MACULA & RETINA CENTER

### Medical Questionnaire

Name \_\_\_\_\_

Date \_\_\_\_\_

Do you have or have had any of the following medical problems? **Circle Yes or No**

Diabetes	Yes / No	Year Diagnosed? _____
High Blood Pressure	Yes / No	Year Diagnosed? _____
Heart Condition	Yes / No	Year Diagnosed? _____
Stroke	Yes / No	Year Diagnosed? _____
Cancer	Yes / No	Year Diagnosed? _____
Lung Disease/Asthma	Yes / No	Year Diagnosed? _____
Skin Disease	Yes / No	Year Diagnosed? _____
Bladder/Prostate	Yes / No	Year Diagnosed? _____
HENT (head, ear, nose, throat)	Yes / No	Year Diagnosed? _____
Tuberculosis	Yes / No	Year Diagnosed? _____
Thyroid	Yes / No	Year Diagnosed? _____
Gastrointestinal	Yes / No	Year Diagnosed? _____
Neurological	Yes / No	Year Diagnosed? _____
Hematologic/sickle cell/anemia/HIV	Yes / No	Year Diagnosed? _____
Lymphatic/Lupus	Yes / No	Year Diagnosed? _____
Muscle Skeletal/arthritis	Yes / No	Year Diagnosed? _____

Do any members of your family (Mother/Father/Siblings etc.) have any of the medical conditions listed above? If so, list relationship and the condition. \_\_\_\_\_

Have you ever been diagnosed with any eye diseases? If so, list diagnosis and year diagnosed.

Does any family member have history of eye diseases? If so, list relationship and disease.

Have you had any previous eye operations? If so, list type of operation and year. \_\_\_\_\_

Have you had any previous operations? If so, list type of operation and year. \_\_\_\_\_

Do you smoke? Yes / No  
If so, how much?

Do you drink? Yes / No  
If so, how much?

Do you exercise? Yes / No  
If so, how much?

Do you use illicit substances/recreational drugs? Yes/ NO

If so, what and how often?

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**WAGNER**  
**MACULA & RETINA CENTER**  
**Medical Questionnaire**

Name \_\_\_\_\_

Date \_\_\_\_\_

**Do you have or have had any of the following symptoms? Circle all that apply. If none, please circle "No."**

**Review of Systems**

<b>General</b>	<b>No</b>	<b>weight change/fever/fatigue</b>
<b>Head</b>	<b>No</b>	<b>headaches/scalp tenderness</b>
<b>ENT</b>	<b>No</b>	<b>earache/ringing/sinus disease/nose bleeds/mouth sores/jaw pain</b>
<b>Cardiovascular</b>	<b>No</b>	<b>chest pain/palpitations/swelling of feet or hands</b>
<b>Respiratory</b>	<b>No</b>	<b>shortness of breath/cough/spitting up blood/wheezing</b>
<b>Gastrointestinal</b>	<b>No</b>	<b>nausea/vomiting/appetite change/change in bowel movement</b>
<b>Musculoskeletal</b>	<b>No</b>	<b>joint pain/stiffness/muscle weakness, pain, cramps/back pain</b>
<b>Skin</b>	<b>No</b>	<b>rash/color change/hair or nail changes/varicose veins/breast lump</b>
<b>Neurological</b>	<b>No</b>	<b>dizziness/numbness/seizures/tingling/paralysis/speech problems</b>
<b>Psychiatric</b>	<b>No</b>	<b>memory loss/confusion/depression</b>
<b>Hematologic</b>	<b>No</b>	<b>bleeding or bruising tendencies/low blood count/vein inflammation</b>

**For Office Use Only**

**Above History Reviewed by** \_\_\_\_\_



