RIDLEY CREEK RETINA

200 E. State Street, Suite 105

Media, PA 19063

Last Name: ____________________________ **First Name:** _____________________________

Address: _____________________________________ **City:** _____________________________

State: _______ **Zip:**_________ **Home Phone:** _________________ **Cell Phone:** _________________

DOB: _____________ **Social Security No:**_________________ **Gender:** _____**Male** ______**Female**

Email address: ____

Marital Status: *Single* *Married* *Divorced* *Widowed* *Other*

Preferred method of contact: *Home* *Work* *Cell* *Email* *Text*

Race: *Native American/Alaska Native* *Asian* *Black/African American* *White* *Other* *Decline*

Ethnicity: *Hispanic or Latino* *Non-Hispanic or Latino* *Unknown*

Primary Language spoken: ____

Emergency Contact Name: ____

Emergency Contact Phone: ___________________ **Relationship:** ____________________

Insurance Company: _________________________ **Policy Number:** _____________________

Pharmacy: _________________________ **Pharmacy Phone Number:** __________________

Pharmacy Address: ____

Referring Physician: ____________________________ **Phone:** _______________________

Address: __________________________________ **City:** _____________________________

State: _______ **Zip:** __________

Primary Care Physician: _________________________ **Phone:** ______________________

Address: __________________________________ **City:** _____________________________

State: _______ **Zip:** ___________

Other Physician: ________________________________ **Phone:** ______________________

Address: __________________________________ **City:** _____________________________

State: _______ **Zip:** ___________**Other doctor's needing reports regarding your eye care:**____

****PLEASE BRING A COPY OF YOUR PRIMARY AND SECONDARY INSURANCE CARDS ALONG WITH A VALID ID****

MEDICAL INFORMATION

Patient Name:________________________ **Today's Date:**______________

Have you had any of the following?

If **YES**, use the lines below to **provide dates** of treatment **and name of Physician**.

Cataract Surgery Right eye ____________________ Left eye ______________________

Retinal laser or surgery Right eye ____________________ Left eye ______________________

Macular Degeneration Right eye ____________________ Left eye ______________________

Glaucoma YES / NO If yes prior treatment(s): _______________________________________

Diabetic Retinopathy YES / NO If yes prior treatment(s):____________________________

Any non eye related surgeries: ____

____

____

____

Allergies: Please check or list all allergies

___ None ___ Penicillin ___ Sulfa ___ Fluorescein ___ Shellfish ___ Latex ___ Iodine

Other: ____

Please list list **ALL ORAL and/or INJECTABLE medications, vitamins, or supplements you are CURRENTLY** taking along with their dosage: ____

____

____

____

____

____

____

Please list **ALL eye drops** you are **CURRENTLY** using: _______________________________

____

____

Insurance Authorization: I hereby assign all medical and/or benefits to which I am entitled, including Medicare or any other private health plan to Ridley Creek Retina. This assignment is considered as valid as an original. I understand that I am financially responsible for any amount not covered by insurance or any amount deemed the subscriber;s responsibility as defined by my insurance company, particularly copayments and deductibles.

PATIENT SIGNATURE: _________________________________ **DATE:** __________________

MEDICAL INFORMATION CONTINUED

Family Medical & Eye History

Have any of your family members had any of the following? Please circle YES or NO and list which blood relative(s) had/have the condition:

Macular Degeneration: **YES / NO** _______________ Diabetic Retinopathy: **YES / NO** _______________

Retinal Detachment: **YES / NO** _________________ Glaucoma: **YES / NO** ________________________

Blindness: **YES / NO** ____________________ Other Eye Disease: **YES / NO**______________________

Diabetes: **YES / NO** ________________________ Heart Disease: **YES / NO** ________________________

High Blood Pressure: **YES / NO** ___________________ Stroke: **YES / NO** ________________________

Cancer: **YES / NO** (type) ____

Other: ____

_____ I do not know my family history

Social History

What is your occupation? _____________________________________ Are you still working? **YES / No**

Do you CURRENTLY smoke cigarettes/ cigars? **YES / NO** If yes, how many packs per day? ________

When did you start smoking? _________________

Are you a FORMER smoker? **YES / NO** If so, how many maximum packs per day? ___________

How many years did you smoke for? ________________ Year quit: ________________________

Do you drink alcohol? **YES / NO** If yes, circle: *Socially/Occasionally* *1-2/day* *3-4/day* *+4/ day*

Any past or present substance abuse? **YES / NO**

(This information is important for medication interactions)

Have you had a blood transfusion since 1977? **YES / NO** If so, when? ___________________________

Is there anything we failed to mention on this form that you would like the doctor to know? **YES / NO**

Your eyes may be dilated for your exam. Dilation will cause the size of your pupils to be enlarged for several hours and can cause glare, blurred vision, and light sensitivity during that time. We suggest you bring dark glasses with you to have upon completion of the exam.

PATIENT SIGNATURE: ____________________________________ **DATE:** __________________

Medical History

Please complete this form in its entirety. Be sure to mark either **YES or NO** for each box. In the line next to the condition, please **provide the year, or approximation of time** in which you have had any of the following medical issues.

YES	NO	
		General
		Recent Weight Loss___
		Lack of Energy___
		Trouble Sleeping___
		Eyes
		Vision Loss___
		Changes in Vision___
		Eye Pain___
		Other___
		Ears, Nose & Throat
		Hearing Loss___
		Sinus Problems___
		Infections___
		Other___
		Cardiovascular
		Heart Attack___
		High Blood Pressure___
		High Cholesterol___
		Heart Murmur___
		Irregular Heart Beat___
		Mitral Valve Prolapsed___
		Chest Pain___
		Circulation Problems___
		Other___
		Respiratory
		Asthma___
		Bronchitis___
		Emphysema___
		Tuberculosis___
		Pneumonia___
		Other___
		Gastrointestinal
		Ulcers___
		Diverticulitis___
		Crohn's Disease___
		Hepatitis___
		Other___
		Genitourinary (Kidney, Bladder, Prostate)
		Kidney Disease___
		Kidney Dialysis___
		Cancer___
		Urinary Infections___
		Other___

YES	NO	
		Musculoskeletal
		Arthritis___
		Osteoporosis___
		Muscle Pain___
		Other___
		Integumentary (Skin / Breast)
		Rashes / Sensitivities___
		Rosacea___
		Skin Cancer___
		Breast Cancer___
		Other___
		Neurological (Nervous System & Brain)
		Seizure___
		Stroke___
		Paralysis / Weakness___
		Parkinson's Disease___
		Alzheimer's___
		Numbness___
		Migraines___
		Other___
		Psychiatric (Mental Illness)
		Depression___
		Psychosis___
		Mania, Bipolar___
		Anxiety___
		Other___
		Endocrine System
		Diabetes (if YES see below)*
		Thyroid Disease___
		Other___
		Hematologic / Lymphatic (Blood)
		Anemia___
		Excessive Bleeding___
		Bruising Easily___
		Clotting Problems___
		Other___
		Allergic / Immunologic
		Lupus___
		Arthritis___
		HIV___
		Other___
		***Diabetes**
		When were you diagnosed?___
		Are you on insulin?___(pump or monitor?)
		Date/Year you started insulin?___
		What was your last Hgb A1c?___ Date:___
		Do you test your blood sugar at home?
		Average Daily Range?___to___

PATIENT SIGNATURE:___________________ **DATE:**___________

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Ridley Creek Retina

Trusted surgical leaders caring for disease of the retina and vitreous

Jason Lange, M.D. Weiye Li, M.D. Andrea Saxon, M.D.

200 E. State Street
Suite 105
Media, PA 19063

PATIENT NAME: ____

Please list anyone with whom we may discuss your care and/or financial information:

Name	Relationship	Phone

Patient Signature: ____ **Date:** ____________

***NO INFORMATION WILL BE RELEASED UNLESS REQUESTING PARTY IS LISTED ABOVE.**

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TO OUR PATIENTS:

While it is our goal that you will receive the best possible result from the treatment we provide, we also recognize that some patients feel dissatisfied with the care they receive from physicians and, as a result, consider bringing medical malpractice lawsuits.

While we do not expect you to be dissatisfied with your care, we feel strongly that the provision of medical care is significantly affected by the physician-patient relationship, each having their own responsibilities. Many times lawsuits against physicians arise out of a misunderstanding or problems that could be resolved without litigation. For that reason, we are asking patients to agree that, should they ever feel that the care provided by the physicians and/or technicians at RIdley Creek Retina constituted a departure from the appropriate standard of care, before initiating a lawsuit against any of the physicians, technicians, and/or Ridley Creek Retina, they will contact this office to arrange mediation to attempt to resolve the problem or dispute.

In the event your do not feel your dissatisfaction with the care provided by the office is resolved by mediation and choose to file a lawsuit against one of our physicians or technicians and/or Ridley Creek Retina, under Pennsylvania law such a lawsuit would have to be filed in the county in which the care was provided (Delaware County). Since there are limited exceptions to this law (such as when the patient is suing physicians who provided care in different counties or when a patient lives in another state), we also request that you will agree that in the event that you do file a lawsuit against anyone associated with this practice, you do so in the Pennsylvania Court of Common Pleas of Delaware County.

Prior to treatment, kindly sign the copy of this letter indicating your agreement that in the event of dissatisfaction with your treatment you will request mediation before filing a lawsuit and that if such mediation is unsuccessful and you decide to file a medical malpractice lawsuit, that you will file it in the Court of Common Pleas for Delaware County.

Again, we have no expectation of dissatisfaction with our care and look forward to working with you.

Sincerely,

Ridley Creek Retina

I, ____________________________, have read the within information and agree that, should I be dissatisfied with the treatment received at Ridley Creek Retina I will take the matter to mediation. If such mediation is unsuccessful, and I determine to file a lawsuit, I will file the lawsuit in the Court of Common Pleas for Delaware County, Pennsylvania.

Patient Signature: ____ **Date:** ________________

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I, ___________________________, acknowledge there is a cancellation fee of $50 for canceling an appointment less than 24 hours or one (1) business day before the scheduled appointment time. This fee is due immediately upon the next appointment. If payment is not made in a timely manner, a bill will be mailed out.

____________________________________ ____________________

Patient signature **Date**