Robert Raden, MD
Ronald Glatzer, MD
5130 Linton Blvd. Suite F7
Delray Beach, FL 33484
Tel: 561-499-8830 Fax: 561-637-8077

Mr. Mrs. Ms. Dr. **Single Married Divorced Widowed**

NAME: **SOCIAL SECURITY#:** **DOB:**

STREET ADDRESS: **Email:**

CITY: **STATE:** **ZIP:**

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

EMERGENCY CONTACT: **PHONE NUMBER:**

Primary Care Physician or Internist: _____

Preferred Pharmacy: _____

Pharmacy address or intersection: _____Phone: _____

Responsible Party Information:
_____ Same as above
If the patient is a child, Name of Guarantor:

Street Address (if different from above)

City: State: Zip:

How were you referred to our office?

Previously seen in our office Yellow Pages Insurance Plan Website/Advertisement

Doctor -Name: Friend/Family- Name: Attorney - Name:

I authorize you to discuss my medical records and care with the following:

_____

The policy in our practice is to collect all known fees when you register, including deductibles, co-payments and co-insurance, based on **estimated** charges. Your final bill may be higher or lower than the estimates we use at registration, since it is based on actual charges for services provided. If it is higher, we may ask for additional payment at the end of your visit, if it is lower, we will promptly refund the amount you over-paid.

I hereby authorize that payment from my medical insurance program or my Medicare benefits be made directly to Retina Center of South Florida, for any unpaid bills for services provided to me on or after today. I understand that I will be financially responsible for any balance not covered by my insurance carrier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature _____ Date _____

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ABOUT THIS FIRST VISIT:
DID ANOTHER DOCTOR SEND YOU?: YES _____ NO _____
DESCRIBE BRIEFLY YOUR EYE OR VISION PROBLEM AND WHICH EYE OR EYES:_____

_____

HOW LONG AGO DID YOU FIRST NOTICE THE ABOVE PROBLEMS?:_____

PAST EYE HISTORY:

_ Eye Injury _ Infections _ Double Vision _ Muscle Imbalance _ Glaucoma
_ Diabetic Eye Disease _ Cataracts _ Retinal Problem _ Macular Degeneration _ Blurry Vision
_ Other, Please Explain:

FAMILY HISTORY:

_ Strabismus - Crossed Eyes _ Glaucoma _ Retinal Problems _ Blindness
_ Diabetes _ Other-Please Explain:

CHECK IF YOU HAVE THE FOLLOWING PROBLEMS:

_ Blurry/Fuzzy Vision _Tearing _Discharge _ Burning _Itching
_ Redness _ Floaters/Cobwebs _ Flashes
_ Other, Please Explain:

What medicines are you currently taking **(PILLS AND DROPS)** : _____LIST ATTACHED

Are you allergic to any medications? Please specify

List all eye surgeries and injuries, which eye, and approximately when they occurred:

MEDICAL HISTORY:

_ HIV or AIDS _Tuberculosis _ Drug or Alcohol Dependence _High Blood Pressure _ Diabetes
_ Thyroid trouble _Cancer _Sinus Infection _ Headaches _Arthritis _Lupus
_ Other, Please Specify

ARE YOU NOW: _Pregnant _Possible Pregnant _Not Pregnant _Unknown _Using Contraceptives

ARE YOU: __ An everyday smoker __ Former smoker __ Never smoked

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PATIENT ACKNOWLEDGEMENT OF HAVING RECEIVED AND READ OR BEEN READ THE NOTICE OF HEALTH INFORMATION PRACTICES

I have been provided the opportunity to read, or it has been read to me, the Notice of Health Information Practices of Retina Center of South Florida.

I understand that Retina Center of South Florida is committed to treating and using protected health information about me responsibly.

I understand my rights as it relates to my records at Retina Center of South Florida and understand how information about me may be used and disclosed.

I understand that my health record is the physical and legal property of Retina Center of South Florida, but the information belongs to me. I may have access to inspect, amend or obtain a copy of my health information. Costs will incur for copies of my records, and appointments must be made with the Privacy Officer to inspect, access or amend my health information.

I understand that Retina Center of South Florida is required to maintain the privacy of my health information. Retina Center of South Florida will require my authorization to release my health information to outside sources with the exception of disclosures for purposes of Treatment, Payment and Healthcare Operations. These may include: access to my health information by Retina Center of South Florida, Inc staff and physicians; billing to myself or a third-party payer; in addition, business associates of Retina Center of South Florida, may from time to time, have access to my health information, but, I am assured that proper Business Associates Agreements are in place, insuring the protection of my health information; upon the physicians best judgment, we may disclose to a family member, relative or close personal friend or any other persons you identify, health information relevant to that person's involvement in my care; may be used for research data; funeral directors; organ procurement; marketing; FDA; public health or legal authorities; and! Or law enforcement purposes.

Retina Center of South Florida may call me with appointment reminders, cancellations and may leave voice mail messages at my home or place of employment.

I have read and understand the Health Information Practices of Retina Center of South Florida.

_____ _____
Signature of Patient Date

_____
Witness

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CONSENT FOR DILATING EYE DROPS

INFORMATION REGARDING DILATING EYE DROPS

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.

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.

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.

I hereby authorize Dr. Robert Raden, Dr. Ronald Glatzer and/or such assistants as may be designated by them to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

This consent will be kept on file and will remain in effect unless you revoke your permission.

_____ _____

Patient (or person authorized to sign for patient) Date

_____

Witness

*****WE DO NOT CHECK FOR EYEGLASS PRESCRIPTIONS OR GLASSES IN THIS OFFICE*****