HIGH COUNTRY MACULA

MICHAEL S. SELIGSON, MD, FACS / FRED L. MCMILLAN, MD
IURI S. GOLUBEV, MD / HENRY H. HUDSON MD, FACS

NEW PATIENT INFORMATION

PERSONAL INFORMATION *(Please Print)* Date: _____

Name**:** _____ **€ Male € Female**

Date of Birth: _____ Age: _____ Social Security No: _____

Phone: _____ Address: _____

City: _____ State: _____ Zip: _____

REFERRING DOCTOR: _____ **Phone:** _____

Address: _____

FAMILY DOCTOR: _____ **Phone:** _____

Address: _____

EMPLOYMENT

Occupation: _____ Employer: _____

Address _____ Phone: _____

MARITAL STATUS: € Single € Married € Widowed € Divorced

Spouse: _____ Social Security No: _____

Address: _____ Phone: _____

COMPLETE IF UNDER 18 YEARS OR A STUDENT

Father: _____ D.O.B. _____ Phone: _____

Employer: _____ Social Security No: _____

Phone: _____ Address: _____

Mother: _____ D.O.B. _____ Phone: _____

Employer: _____ Social Security No: _____

Phone: _____ Address: _____

EMERGENCY CONTACT

Name: _____ **Relationship:** _____

Phone: _____ **Address:** _____

INSURANCE: _____ **Group No:** _____ **Member No:** _____

FINANCIAL ASSIGNMENT AND AGREEMENT: HIGH COUNTRY MACULA, RETINA & Vitreous PC is committed to seeing every patient who has need. It is important to us that all patients receive appropriate care. However, we are required to charge each patient our set fees regardless of whether or not he/she has insurance. We will work with each uninsured patient on an individual basis to set up a reasonable payment plan if he/she does not have the means to pay for the entire visit at the time of examination. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. It is each patient's responsibility to pay any deductible amount, co-insurance, or any non-covered service not paid for by your insurance. Please let us know if you suggestions as to know we can better address your needs.

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me by High Country Macula, Retina and Vitreous, PC. I authorize High Country Macula, Retina, and Vitreous, PC and its agents to my medical information as needed to determine these benefits or the benefits assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment. I further understand that I am ultimately responsible for ensuring all payments are made.

Signed: (Patient or Parent if Minor) Date:

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(888) 982-5716

EYE HISTORY

NAME: _____ **AGE:** _____ **D.O.B:** _____ **Date:** _____

Do you wear glasses? □ NO □ YES – How Long? _____ Lenses last changed: _____

2. Do you wear contact lenses? □ NO □ YES – How Long? _____ Type of Contact lens: _____
3. Do you have problems reading? □ NO □ YES
4. What visual symptoms are you experiencing? Please circle all that apply.

Right Eye: Eye Pain Blurred Vision Flashes of Light Halos Light Sensitivity
Double Vision Decreased Vision Floaters Other: _____
When did these symptoms start? _____

Left Eye: Eye Pain Blurred Vision Flashes of Light Halos Light Sensitivity
Double Vision Decreased Vision Floaters Other: _____
When did these symptoms start? _____

5. Have you ever had an eye injury? Please describe: _____
_____
6. Have you ever had eye surgery or laser treatment? □ NO □ YES --If yes, please fill out below:
   a. Date: _____ Eye: _____ Type of Surgery: _____ Surgeon: _____
   b. Date: _____ Eye: _____ Type of Surgery: _____ Surgeon: _____
   c. Date: _____ Eye: _____ Type of Surgery: _____ Surgeon: _____
   d. Date: _____ Eye: _____ Type of Surgery: _____ Surgeon: _____
   e. Date: _____ Eye: _____ Type of Surgery: _____ Surgeon: _____
7. Have you had cataract surgery? □ NO □ YES Did you have a lens implant? □ NO □ YES
8. Do you have glaucoma? □ NO □ YES
9. Are you being treated for any medical conditions? Please circle all that apply:
   Diabetes Type I or II Heart Disease High Blood Pressure Stroke Arthritis
   Other: _____
10. Are you pregnant? □ NO □ YES
11. Does anyone in your immediate family (mother, father, sister, brother, etc.) have a history of eye problems? □ NO □ YES -- If yes, please list family relationship.
    Retinal Disease _____ Diabetes _____ Cataracts _____ Glaucoma _____
12. List all medications you are currently taking (i.e. aspirin 325 twice daily, etc.): _____
_____
_____
13. Are you allergic to any medications? Please list: _____

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MEDICAL RECORD RELEASE

Date: _____

Doctor records are being requested FROM (Referring/PCP): _____

Fax: _____

We have currently received a referral of a mutual patient. Please supply the following Medical Records for the care of this patient. Do not hesitate to call our office if you have any questions. Thanks!

PATIENT: _____

Date of Birth: _____

Phone Number: _____

Records of: _____
_____
_____
_____
_____

Restrictions to released information:
_____
_____
_____

I, _____, expressly authorize the release of my medical records to High Country Macula, Retina, and Vitreous, PC, and Dr. Seligson.

_____
Patient Signature **Date**

Please fax or mail to:

High Country Macula, Retina, and Vitreous,
2055 SOUTH PACHECO ST., SUITE 600
SANTA FE, NEW MEXICO, 87505
Fax: (505) 982-5718
For questions call: (505) 982-5716

Please fax or mail to:

PC High Country Macula, Retina, and Vitreous, PC
4343 PAN AMERICAN FWY NE, SUITE 224
ALBUQUERQUE, NEW MEXICO, 87107
Fax: (505) 344-5404
For questions call: (505) 344-5400

For Staff Use Only: Date Request Faxed/Mailed: _____ Employee Initials: _____
Date Records Received: _____ Employee Initials: _____

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RELEASE OF MEDICAL CHART INFORMATION

I hereby release information regarding my medical chart to the following person (s):

_____

Name

_____

Signature Date

For your privacy, will you grant us permission to call and/or leave messages at the phone number[s] you have provided us? __**Yes** __**No**

This acknowledgement page should be retained in patient's records. If acknowledgement could not be obtained from patient, the reason[s] must be documented below.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT RECEIPT

By my signature below, I acknowledge that I have received High Country Macula, Retina, and Vitreous, PC's Notice of Privacy Practices.

_____

Name

_____

Signature Date

For your privacy, will you grant us permission to call and/or leave messages at the phone number[s] you have provided us? __**Yes** __**No**

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