Please complete as much as possible and bring this information to your appointment. Thank you.

Northeast Wisconsin **Retina** Associates, sc

Intake Information

Last name First Middle initial

Address Zip City State

Billing address (if different)

Home phone Work phone Cell

Email Preferred contact # ○ Home ○ Work ○ Cell ○ Email ○ Other

SS# Date of birth Age

Gender ○ M ○ F Marital status

Preferred language Race Ethnicity

Employer City Occupation

If married, spouse name Phone

Person to contact in case of an emergency who does not live in the same household as the patient:

ER contact name Phone Relationship

If the patient is a minor, please list both parents' names, phones and addresses on the lines below:

Mother's first name Last name Phone

Address City State Zip

Father's first name Last name Phone

Address City State Zip

If the patient resides in a nursing home, please provide the information below:

Name of care facility Phone

Address of facility

Street City State Zip

Is patient enrolled in a hospice program? ○ Yes ○ No Effective date

Medical Provider and Insurance Information

Medical Provider(s)

Referring doctor name

Address Phone

Primary care doctor name

Address Phone

General ophthalmologist name

Address Phone

Specialist name

Address Phone

Please be sure to bring your insurance cards to the appointment so we may place a copy in your file.

You will be expected to pay any copays indicated by your insurance company on the day of your visit. We accept cash, checks, Visa and Mastercard.

If you have a Medicare card, even if you are not currently sending claims to Medicare, we need the ID number to access the "Medicare Eligibility Files" online.

Medicare ID Number

Primary Medical Insurance Company

Policy # Group #

Subscriber's name Subscriber's date of birth

Subscriber's Social Security # Subscriber's relationship to patient

Subscriber's employer

Name of employer, city and state

Secondary Medical Insurance Company

Policy # Group #

Subscriber's name Subscriber's date of birth

Subscriber's Social Security # Subscriber's relationship to patient

Subscriber's employer

Name of employer, city and state

Patient name _____ Date _____

○ Yes ○ No Have you been treated for any **EYE conditions** or had any **EYE surgeries**?

Condition/Surgery	Eye(s)	Approximate Date

○ Yes ○ No Are you currently using any **eye drops** or **eye vitamins**?

Medication	Eye(s)	Frequency

Do you have any of the following **health conditions**?

○ Yes ○ No Type I Diabetes Year diagnosed _____

○ Yes ○ No Type II Diabetes Year diagnosed _____

○ Yes ○ No Hypertension Describe _____

○ Yes ○ No High cholesterol Describe _____

○ Yes ○ No Heart disease Describe _____

○ Yes ○ No Kidney disease Describe _____

○ Yes ○ No Lung disorders Describe _____

○ Yes ○ No Stomach disorders Describe _____

○ Yes ○ No Musculoskeletal Describe _____

○ Yes ○ No Neurological Describe _____

○ Yes ○ No Blood disorders Describe _____

○ Yes ○ No Cancer Describe _____

○ Yes ○ No Other Describe _____

○ Yes ○ No Have you had any **OTHER surgeries**, not including eye surgeries?

Type of Surgery	Approximate Date

Please list all of your current **medications and dosages**, including vitamins and supplements.

Medication	Dosage	Medication	Dosage

○ Yes ○ No Do you have any **allergies** to medications or foods? If so, describe reaction.

Allergy	Reaction

○ Yes ○ No Is there any **family history** of the following conditions?
If so, please state relationship (mother, father, sister, etc....)

Condition	Relationship
Diabetes	
Glaucoma	
Retinal detachment	
Macular degeneration	

Smoking history: ○ Never ○ Former ○ Current, some days ○ Current, every day

Alcohol intake: ○ None ○ Occasional/social ○ 1-2 drinks per day ○ 3 or more per day