



2705 Jefferson Road, Athens, GA 30607

To prepare for your upcoming visit to Athens Retina Center, here is a list of helpful suggestions.

1. Please be prepared to spend 2-4 hours for your initial appointment.

- This visit includes a detailed history, comprehensive eye and retinal examination, additional testing as needed, discussion of your diagnosis and treatment plan with your doctor, and initial treatment if needed.

2. Your eyes will be dilated (eye drops to enlarge your pupil) for your retina to be examined.

- While the dilation wears off after several hours, your vision may be blurred and your eyes may be light sensitive after your visit. It's best to have someone to drive you after your initial appointment. For subsequent appointments, you can judge whether or not you need a driver.

3. It is often helpful to have a family member or friend accompany you to your initial appointment.

- Your doctor may give you a large amount of information and having “another set of ears” helps you recall what was discussed during your visit.

4. Please bring to your appointment:

- “New Patient” forms completed before arriving
- Your current eyeglasses or contacts
- A list of your medications, including eye drops and vitamins.
- List and dates of past medical issues and surgical procedures
- List of doctors you are seeing and the referring doctor’s name
- A copy of your insurance card and a photo ID, such as a driver’s license.
- Copay payment due at time of service OR \$750 initial deposit for non-insured patients due at check-in by cash or credit card only.

If you have any questions, please call our office at 706-543-3200

ATHENS RETINA CENTER

PATIENT INFORMATION

PLEASE BRING AND PROVIDE COMPLETE INFORMATION FOR EACH ITEM.

(LEGAL) FIRST NAME _____ MI _____ LAST _____

LOCAL ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE # (____) ____ - ____ CELL (____) ____ - ____ WORK PHONE (____) ____ - ____

DATE OF BIRTH ____ - ____ - ____ SEX ____ SOCIAL SECURITY# ____ - ____ - ____ MARITAL STATUS: S M W D

RACE: _____ ETHNICITY: (Please circle) Hispanic or Latino Non- Hispanic or Latino Other

EMAIL ADDRESS: _____ PREFERRED LANGUAGE: _____

PRIMARY INSURANCE HOLDER _____ SS# ____ - ____ - ____ Date of Birth ____ - ____ - ____

| | | |
|--------------------|------------|---------------------------|
| REFERRED BY | | |
| NAME: _____ | (OD MD DO) | PHONE: ____ - ____ - ____ |
| ADDRESS: _____ | CITY _____ | STATE _____ ZIP _____ |

FAMILY PHYSICIAN _____ (MD ,OD) PHONE # ____ - ____ - ____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT : _____ PHONE: (____) - ____ - ____

RELATIONSHIP TO PATIENT: _____

\$750 Deposit due at Check-In for Non-Insured Patients Cash _____ Credit Card _____ Amount Paid: _____

Patient Signature: _____ Date: _____

IF PATIENT IS A MINOR OR DEPENDENT

NAME OF RESPONSIBLE PARTY: _____ RELATIONSHIP TO PATIENT: _____

RESPONSIBLE PARTY ADDRESS: _____ Date of Birth ____ - ____ - ____

CITY: _____ STATE _____ ZIP: _____ PHONE: (____) ____ - ____

ACCIDENT RELATED (CIRCLE) WORK AUTO OTHER

WHAT HAPPENED? _____

PERSON TO CONTACT _____ PHONE (____) ____ - ____

PATIENT NAME: _____ DATE: _____

OCULAR HISTORY: _____

Current problem with vision: _____

Past eye problems and surgeries: _____

Current eye medication: _____

PLEASE CIRCLE RT (RIGHT EYE) OR LT (LEFT EYE)

- | | | | | | |
|----|----|-----------------------------|----|----|---------------------------------------|
| RT | LT | Lazy Eye since birth | RT | LT | Burning |
| RT | LT | Eye glasses worn @childhood | RT | LT | Bulging forward |
| | | @adulthood | RT | LT | Double Vision |
| RT | LT | Eye Injury: | RT | LT | Tearing Eye |
| RT | LT | Blind Spot in Vision | RT | LT | Eye Redness |
| RT | LT | Crooked/Wavy lines | RT | LT | Eye Pain |
| RT | LT | Floating Spots/Cobwebs | RT | LT | Itchy |
| RT | LT | Droopy Lid | RT | LT | Foggy/Cloudy Vision |
| RT | LT | Glare or Halos | RT | LT | Matted eye in morning |
| RT | LT | Loss of side vision | RT | LT | Excessive Light Sensitivity |
| RT | LT | Eye Discharge | RT | LT | Feels like sand/lash in eye |
| RT | LT | Blurring of Vision | RT | LT | Rapid flashing lights (strobe effect) |
| RT | LT | Yellow tinted vision | | | |

MEDICAL HISTORY

Do you take aspirin, Advil or any other over the counter pain medicines? YES NO

If YES, please list: _____

Do you take dietary supplements or herbal supplements? YES NO

If YES, please list: _____

Current Medical Problems:

Current Medications & Dosages:

| | |
|---|--|
| | |
| | |
| | |
| Cancer <input type="checkbox"/> None <input type="checkbox"/> Yes (please list) | |
| Past Surgeries: | |
| | |
| | |

ALLERGIES: None Yes (Please list): _____

CHECK ANY MAJOR OR RECENT SYMPTOMS

| | | | |
|--|--|---|--|
| Constitutional: <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Weakness <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss | Cardiovascular: <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Calf Pain <input type="checkbox"/> Chest pressure or discomfort <input type="checkbox"/> Irregular Heartbeat/palpitations <input type="checkbox"/> Leg Swelling <input type="checkbox"/> Tachycardia | Metabolic/Endocrine: <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Excessive Hunger <input type="checkbox"/> Excessive Urination | Integumentary: <input type="checkbox"/> Abnormal hair distribution <input type="checkbox"/> Dry Skin <input type="checkbox"/> Hives <input type="checkbox"/> Itching skin <input type="checkbox"/> Nail Changes <input type="checkbox"/> Rash <input type="checkbox"/> Skin Changes <input type="checkbox"/> Skin Lesions <input type="checkbox"/> Skin nodules <input type="checkbox"/> Skin sores <input type="checkbox"/> Ulcer |
| HEENT: <input type="checkbox"/> Exophthalmos <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hoarseness <input type="checkbox"/> Lump in Neck <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Sore Throat <input type="checkbox"/> Tinnitus <input type="checkbox"/> Vertigo | Gastrointestinal: <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Black Tarry Stools <input type="checkbox"/> Constipation <input type="checkbox"/> Decreased Appetite <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Food Intolerance <input type="checkbox"/> Heartburn <input type="checkbox"/> Increased Appetite <input type="checkbox"/> Jaundice <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting | Neurological: <input type="checkbox"/> Balance Disturbances <input type="checkbox"/> Dizziness <input type="checkbox"/> Focal Weakness <input type="checkbox"/> Gait Disturbance <input type="checkbox"/> Headache <input type="checkbox"/> Memory Difficulty <input type="checkbox"/> Numbness of Extremities | Musculoskeletal: <input type="checkbox"/> Arthralgia <input type="checkbox"/> Back Pain <input type="checkbox"/> Fracture <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Muscle Cramping <input type="checkbox"/> Muscle Weakness |
| Respiratory: <input type="checkbox"/> Asthma <input type="checkbox"/> Cough <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Difficulty Breathing on Exertion <input type="checkbox"/> Coughing up of Blood <input type="checkbox"/> Wheezing | Genitourinary: <input type="checkbox"/> Painful/Difficult Urination <input type="checkbox"/> Genital Lesions <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Irregular Menses <input type="checkbox"/> Urethral Discharge <input type="checkbox"/> Urgency | Psychiatric: <input type="checkbox"/> Depressed Mood <input type="checkbox"/> Emotional Changes <input type="checkbox"/> Euphoria <input type="checkbox"/> Frequent Nightmares <input type="checkbox"/> Hallucinations <input type="checkbox"/> Insomnia <input type="checkbox"/> Irritability <input type="checkbox"/> Nervousness <input type="checkbox"/> Stress | Immunologic: <input type="checkbox"/> Environmental Allergies <input type="checkbox"/> Food Allergies <input type="checkbox"/> Seasonal Allergies |
| | | | Hematologic/Lymphatic <input type="checkbox"/> Bleeding <input type="checkbox"/> Bruising <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Tender Lymph Nodes |
| | | | Other: _____ _____ _____ _____ |

FAMILY HISTORY

Any eye disease or blindness in relative? YES NO If yes, who? _____

What kind of problem(s)? _____

Father: Still living? YES NO Age: _____

List medical problems: _____

Mother: Still living? YES NO Age: _____

List medical problems: _____

SOCIAL HISTORY

Do you drive? YES or NO

Do you drive at night? YES or NO

Do you live with anyone? YES or NO If yes, Whom: _____

Do you have pets or animal exposure? YES or NO

If YES, what type of animals? _____

Do you use tobacco products? YES or NO

If YES, what type of tobacco? _____

How frequently? # packs per day or week? _____

Do you drink alcoholic beverages? YES or NO

If YES, how frequently? Drinks/day? _____

Do you use any recreational drugs? YES or NO

If YES, type of drugs and frequency: _____

Do you eat undercooked meat or fish products? YES or NO

Are you currently employed? YES or NO

Are you retired? YES or NO

What is or was your occupation? _____

I have completed this medical history to the best of my ability:

Signature: _____

Date: _____

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

FINANCIAL POLICY

- The Patient is responsible for all fees. Full payment is due at time of service unless other arrangements have been made in advance.
- We will accept assignment on your insurance benefits and will expedite insurance claim processing to insure prompt payment and accurate reimbursement.
- Deductibles and copayments are due at time of service on all insurance plans.
- Patients covered under non-participating insurances must pay 100% of any unpaid deductible or out of pocket expenses under the terms of their contract.
- If insurance payment is not received within 60 days of your date of service, the Patient becomes responsible for the outstanding balance.
- Late charges of 2% will be assessed against the outstanding balance for any amount owed over 60 days. This charge will be assessed monthly until the account is paid in full.
- Delinquent unpaid balances including previous adjustments will be forwarded to a collection agency or attorney.

I have read and understand this financial policy and agree to its terms. I agree to pay for services rendered. I agree to pay attorney fees and collection costs in the event it becomes necessary to retain such services for collection of my account.

I authorize the release of medical information and records concerning my treatment to Medicare, Medigap and/or other insurance companies and assign my claim for medical benefits to the extent permitted under applicable law or insurance agreements. I release all legal responsibility or liability that may arise from the above authorizations and agreements:

Patient Signature _____ **Date** _____

Responsible Party _____ Date _____

I authorize the physicians and staff of Athens Retina Center to dilate, test and examine my eyes to the extent necessary to determine the underlying cause of my visual difficulties and to offer possible treatment options available to me.

Patient Signature _____ **Date** _____

Guardian _____ Date _____

**ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES
ATHENS RETINA CENTER**

As provisioned by the Health Insurance Portability and Accountability Act of 1996 we must provide you with a detailed notice in writing of our privacy practices. By signing this notice you have acknowledged receipt of our Notice of Privacy Practices. (04/27/2016)

Patient Name (Print): _____ Date of Birth: _____

I authorize My Primary Care Doctor _____ to be sent my records from Athens Retina Center: **Yes No**

I authorize the following person(s) to access to my records from Athens Retina Center:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices Policy of Athens Retina Center and its physicians Mohan N. Iyer, M.D. and Victor T. Copeland, M.D.

Patient Signature: _____ Date: _____

This acknowledgement page should be retained in the patient's record.
If an acknowledgement could not be obtained from the patient, note the reasons below.

***IF YOU WOULD LIKE A COPY OF OUR PRIVACY POLICIES PLEASE ASK THE
FRONT DESK***