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)

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

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 □ None □ Yes (please list)

Past Surgeries: ________________________________

ALLERGIES:  None  Yes (Please list): ________________________________
# New Patient

## What to expect

<table>
<thead>
<tr>
<th>Constitutional:</th>
<th>Cardiovascular:</th>
<th>Metabolic/Endocrine:</th>
<th>Integumentary:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fatigue</strong></td>
<td><strong>Arrhythmia</strong></td>
<td><strong>Cold Intolerance</strong></td>
<td><strong>Abnormal hair distribution</strong></td>
</tr>
<tr>
<td><strong>Fever</strong></td>
<td><strong>Calf Pain</strong></td>
<td><strong>Heat Intolerance</strong></td>
<td><strong>Dry Skin</strong></td>
</tr>
<tr>
<td><strong>Night Sweats</strong></td>
<td><strong>Chest pain or discomfort</strong></td>
<td><strong>Excessive Thirst</strong></td>
<td><strong>Hives</strong></td>
</tr>
<tr>
<td><strong>Weakness</strong></td>
<td><strong>Irregular Heartbeat/palpitations</strong></td>
<td><strong>Excessive Hunger</strong></td>
<td><strong>Itching skin</strong></td>
</tr>
<tr>
<td><strong>Weight Gain</strong></td>
<td><strong>Leg Swelling</strong></td>
<td><strong>Excessive Urination</strong></td>
<td><strong>Nail Changes</strong></td>
</tr>
<tr>
<td><strong>Weight Loss</strong></td>
<td><strong>Tachycardia</strong></td>
<td></td>
<td><strong>Rash</strong></td>
</tr>
</tbody>
</table>

**HEENT:**

| __Exophthalmos__ | __Abdominal Pain__ | __Balance Disturbances__ | __Arthralgia__ |
| __Hearing Loss__ | __Black Tarry Stools__ | __Dizziness__ | __Back Pain__ |
| __Hoarseness__   | __Constipation__   | __Dizziness__ | __Fracture__ |
| __Lump in Neck__ | __Decreased Appetite__ | __Focal Weakness__ | __Joint Stiffness__ |
| __Nasal congestion__ | __Diarrhea__ | __Gait Disturbance__ | __Muscle Cramping__ |
| __Sinus Problems__ | __Difficulty Swallowing__ | __Headache__ | __Muscle Weakness__ |
| __Sore Throat__  | __Food Intolerance__ | __Memory Difficulty__ | __Tenderness__ |
| __Tinnitus__     | __Heartburn__     | __Numbness of Extremities__ | __Lymphadenopathy__ |
| __Vertigo__      | __Increased Appetite__ |                  | __Tender Lymph Nodes__ |

**Respiratory:**

| __Asthma__ | __Painful/Difficult Urination__ | __Depressed Mood__ | __Environmental Allergies__ |
| __Cough__   | __Genital Lesions__            | __Emotional Changes__ | __Food Allergies__ |
| __Difficulty Breathing__ | __Blood in Urine__ | __Euphoria__ | __Seasonal Allergies__ |
| __Difficulty Breathing on Exertion__ | __Irregular Menses__ | __Frequent Nightmares__ |                 |
| __Coughing up of Blood__ | __Urethral Discharge__ | __Hallucinations__ |                 |
| __Wheezing__ | __Urgency__                  | __Insomnia__ |                 |

**Genitourinary:**

| __Depressed Mood__ | __Emotional Changes__ | __Euphoria__ | __Food Allergies__ |
| __Frequent Nightmares__ | __Hallucinations__ | __Insomnia__ | __Seasonal Allergies__ |
| __Hallucinations__ | __Irritability__ | __Nervousness__ |                 |
| __Insomnia__ | __Nervousness__ | __Stress__ |                 |

**Psychiatric:**

| __Environmental Allergies__ | __Food Allergies__ | __Seasonal Allergies__ | __Other__ |
| __Other__ |                      |                         |           |

**Immunologic:**

| __Other__ |                      |                         |           |

**Musculoskeletal:**

| __Arthralgia__ | __Back Pain__ | __Fracture__ | __Joint Stiffness__ |
| __Muscle Cramping__ | __Muscle Weakness__ |                   |                 |

**Hematologic/Lymphatic:**

| __Arthralgia__ | __Back Pain__ | __Fracture__ | __Joint Stiffness__ |
| __Muscle Cramping__ | __Muscle Weakness__ |                   |                 |

**Constitutional:**

- 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:** ________________________________

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New Patient Packet with What to expect 2016.doc
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*