



**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 \$250 initial deposit for self pay 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: \_\_\_\_\_

\$250 Deposit due at Check-In for Standard Pay Patient 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 (\_\_\_\_) \_\_\_\_ - \_\_\_\_





**CHECK ANY MAJOR OR RECENT SYMPTOMS**

<b>Constitutional:</b>	<b>Cardiovascular:</b>	<b>Metabolic/Endocrine:</b>	<b>Integumentary:</b>
<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	<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	<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	<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
<b>HEENT:</b>	<b>Gastrointestinal:</b>	<b>Neurological:</b>	<b>Musculoskeletal:</b>
<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	<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	<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	<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
			<b>Hematologic/Lymphatic</b>
			<input type="checkbox"/> Bleeding <input type="checkbox"/> Bruising <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Tender Lymph Nodes
<b>Respiratory:</b>	<b>Genitourinary:</b>	<b>Psychiatric:</b>	<b>Immunologic:</b>
<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	<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	<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	<input type="checkbox"/> Environmental Allergies <input type="checkbox"/> Food Allergies <input type="checkbox"/> Seasonal Allergies
			<b>Other:</b>
			_____ _____ _____ _____

**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 to 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\***