IDAHO RETINA CENTER PLLC

Legal Name: ____Preferred Name:________________

Date of Birth :_________________ Phone Number:_____________________________

Address:____

City: ______________________________ State:_____________ Zip Code: ____________________

Gender : ☐ Male ☐Female Social Security Number:____________________________

Marital Status :
☐Single
☐Married
☐Divorced

Race:
☐Native American/Alaskan
☐Caucasian/White
☐Asian
☐African American/Black
☐Hispanic/Latino
☐Native Hawaiian/ Pacific Islander

Language Preference
☐English
☐Spanish
☐Other: ___________

Emergency Contact:
Relationship:_____________________________________Phone:______________________

Family Doctor:____________________________________ Phone:______________________

Referring Doctor:__________________________________ Phone:______________________

Responsible Party: (If minor, guardian, or Power of Attorney)

Name:______________________________Phone: _____________DOB:___/____/____

Address:____

Relationship to patient:____________________

Primary Insurance Information:
Name of Insurance:____________________
Name of policyholder:_________________
DOB:_______________
ID#:____________________________
Relationship to patient:________________

Secondary Insurance Information:
Name of Insurance:___________________
Name of policyholder:_________________
DOB:_______________
ID#:____________________________
Relationship to patient:________________

IDAHO RETINA
CENTER PLLC

Name :______________________________________ DOB:_______/________/_______

MARK ALL SYMPTOMS YOU ARE CURRENTLY EXPERIENCING-

☐Loss of Vision ☐Eye Pain/Soreness ☐Other:_____________________
☐New Floaters ☐Distortion
☐Flashes of Light ☐Blurred Vision

MARK ALL MEDICAL DIAGNOSES THAT APPLY TO YOU, BOTH PRESENTLY AND IN THE PAST- (If there is more than one presentation of your diagnosis, please circle the one that applies)

☐Alzheimer's
☐Anemia
☐Anxiety
☐Arthritis - Osteo / Rheumatoid
☐Arrhythmia (irregular heart beat)
☐Asthma
☐Bleeding Disorder
☐Cancer-
Type:___________________
☐COPD
☐Congestive Heart Failure
☐Dementia
☐Depression
☐Diabetes -Type I / Type II
☐Emphysema
☐GERD/Gastric Reflux
☐High Blood Pressure
☐High Cholesterol
☐Heart Attack
☐Kidney Disease
☐Leukemia
☐Lupus
☐Migraines -Ocular/Classic
☐Prostate Complications
☐Thyroid- Hyper/Hypo
☐Seizure Disorder
☐Stroke

Other:____

OCULAR HISTORY

☐No Significant History
☐Bell's Palsy
☐Cataract
☐Choroidal Nevus
☐Choroidal Melanoma
☐Diabetic Retinopathy
☐Double Vision
☐Dry Eye Syndrome
☐Fuch's Dystrophy
☐Glaucoma
☐Herpes Simplex
☐Iritis
☐Lazy Eye(amblyopia)
☐Macular Degeneration
☐Macular Hole
☐Macular Pucker
☐Nerve Palsy
☐Ocular Migraines
☐Retinal Detachment
☐Retinal Vein Occlusion
☐Retinal Artery Occlusion
☐Retinal Tear

Other:____

OCULAR SURGERIES

☐Cataract Surgery
☐Corneal Surgery
☐Eyelid Surgery
☐Eye Muscle Surgery
☐Glaucoma Surgery
☐Laser Surgery
☐LASIK
☐Retinal Surgery

Reason for surgery, date, and Surgeon :

____

IDAHO RETINA
CENTER PLLC

FAMILY HISTORY

☐Blindness ☐Cataract ☐Cancer ☐Diabetes
☐Retinal detachment/tear ☐Stroke ☐Glaucoma ☐Macular degeneration
☐Heart Attack ☐ High Blood pressure

Are you currently an every day smoker: ☐ Yes ☐No
How many packs per day? :____________________
Former smoker When did you quit? :____________________
Never smoker ? ☐Yes ☐No

MEDICATIONS List all current medications you are taking (including prescription, over-the-counter, herbals, vitamins, mineral supplements, dietary supplements) Attach a list if necessary .

Name	***Dose***	***Frequency***

Do you have any ALLERGIES TO MEDICATIONS? ☐Yes ☐No
If YES, please list the medications and the reaction to them (including difficulty breathing, confusion, cough, dizziness, swelling of limbs, headache, lethargy, nausea, vomiting, rash, hives)

IDAHO RETINA CENTER PLLC

MEDICAL CONSENT

I, the undersigned, being the person whose name appears hereafter designated as patient or being a person legally authorized to consent to services on behalf of the patient, do hereby consent and authorize the doctors of Idaho Retina Center, PLLC ("Doctor Office") to (1) discuss, document and securely store my health history/information and (2) provide an in-office or bedside examination of my eyes and/or body as deemed necessary by my doctor in order to appropriately arrive at a diagnosis and treatment plan. I understand that some preliminary information gathering and basic testing done in the office is often performed by member of my doctor's staff as well as by the doctor him (her)self and this routine work-up often include the instillation of eye drops for various reasons - such as to check eye pressure and to dilate the pupils. Because of this, this consent and authorization also extends to and includes: staff doctors, interns/students/nurses/nurse's aides, technicians and agents and employees of the Doctor's Office providing services to the patient. I understand that the patient is under the care of the attending doctor and that such doctor is responsible for determining the nature and course of treatment for the patient.The attending doctor will recommend treatment for the patient and the patient will have to decide whether to follow those recommendations or not. The consent given here DOES NOT extend to initiation of any oral or IV medication nor any surgical procedures,injections or lasers performed whether in the office or at a surgical facility. Separate consent must be obtained for any of these procedures.

RELEASE OF INFORMATION

The undersigned agrees that to the extent necessary to determine responsibility for payment and to obtain reimbursement, the Doctor Office may disclose portions of the patient's record, including their medical records, to any person or entity which is or may be responsible for all or any portion of the Doctor's Office charges, including but not limited to insurance companies, health care service plans, workers compensation carriers, medical or utilization review organization designated by any of the foregoing, or to any other person or entity as necessary in connection with such payment or reimbursement. I authorize any holder of medical or other information about me to release shame and copies of any medical records to Doctor's Office, the Health Care Financing Administration, its agents or carriers, and my insurance carrier (s), necessary to determine benefits and/or to process claims for this and all related claims on my behalf, now or in the future. I request my insurance company(ies) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my doctor on my behalf. HIPAA NOTICE. I have been given the opportunity to review a Notice of Privacy Practice disclosing how my patient health information may be used and disclosed, and how I can get access to my individually identifiable health information. DISPOSITION OF TISSUE, ETC. I authorize the Doctor Office to retain, preserve, and use for scientific purposes or disposal at the convenience of the Doctor Office, any specimens or tissues taken during my treatment.

PRIOR AUTHORIZATION

I understand that some insurance companies require prior authorization for certain procedures, and that maximum reimbursement and coverage may not be received if prior authorization is not obtained. I assume the responsibility of obtaining such authorization if necessary. NOTICE: Your health insurance plan may require you to obtain some medical services from certain providers in order to be fully covered for those services at the Doctor's Office. In most cases, your insurance card will list a telephone number that you may call to obtain your health insurance benefit coverage and any restrictions on choosing a provider. Idaho Retina Center offers a full range of the services you may need; however, in order to

receive maximum insurance payment you need to know your health insurance benefits coverage and which providers the insurance will fully pay.

FINANCIAL AGREEMENT

I understand that, even though I may have insurance and authorize this office to submit charges on my behalf, I am financially responsible for all charges not paid by my insurance. I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, or any other health plans to Idaho Retina Center PLLC/Dr. Ali Torab Parhiz. I hereby authorize said assignee to release all information necessary to secure payment. I am aware that a co-payment may be required for each visit, and if there is no insurance coverage, payment in full is required for services unless prior payment arrangements have been discussed.

This medical facility reserves the right to charge a Returned Check fee.
If I choose to pay all charges myself and not bill my insurance, I will notify this medical facility prior to receiving service. Should the account be referred to an attorney or collection agency for collections, I agree to pay any reasonable attorney's fees, collection expenses and interest at the statutory rate on all delinquent accounts, whether the account is referred to a collection agency.

MISSED APPOINTMENTS

I agree to pay the cost for all visits missed or canceled late unless I notify Idaho Retina Center of the cancellation at least 24 hours in advance of the scheduled appointment. I recognize that missed appointments and late cancellations will be charged directly to me. These fees will not be billed to my insurance. Notify your provider no less than 24 hours in advance of any cancellations. Appointments are the responsibility of the client and/ or parents and reminders from the provider should not be expected. If you cancel or miss an appointment without proper notice, you will be charged a $100 no-show fee or $25 late- cancelation fee and will not be allowed to reschedule until that fee is paid.

THE UNDERSIGNED CERTIFIES THAT THEY HAVE READ AND UNDERSTAND THE FOREGOING AND EITHER IS THE PATIENT NAMED OR IS DULY AUTHORIZED BY THE PATIENT OR BY LAW TO ACCEPT THE TERMS ON THE PATIENT'S BEHALF.

Signature of Patient/Legal Representative:

X____ Date:______________

Printed Name: __________________________________

Relation (if patient is not guarantor):____________________________________