

Piedmont Retina Specialists Update Patient Information Form

Please review the following and complete if changed since your last visit. Please provide your insurance card(s) for us to copy as well. Thank you!

Name: _____ Date: _____
(Last) (First) (Middle) (Nickname)

NEW Address: _____

NEW City, State, Zip Code: _____

Home Phone: _____ Mobile/Cell Phone: _____

Work Phone: _____ Other: _____

Email address: _____ ***By providing my email, I understand that medical information may be sent to this email address.***

Emergency Contact: _____ Relationship: _____

Emergency Contact Telephone #'s _____

Eye Doctor: _____ Primary Doctor(s): _____

Reason for Visit today: _____

List any eye problems or eye surgery since last visit: _____

Employed/Retired/Student/Unemployed Employer: _____

Marital Status (circle one): Married/Divorced/Separated/Widowed/Single/Partner/Child

Since last visit have you been diagnosed with any of the following? Please provide details if "Yes" circled.

Yes No Diabetes _____

Yes No High Blood Pressure _____

Yes No Heart Disease _____

Yes No Respiratory Disease _____

Yes No Gastrointestinal Disease _____

Yes No Liver Disease or Hepatitis _____

Yes No Prostate Disease _____

Yes No Cancer _____

Yes No Kidney Disease _____

Yes No HIV, Infectious Disease _____

List NEW medications, including dose:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

List NEW eye drops that you are currently using:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Please list any drug allergies or note below if you are allergic to Latex or adhesives.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Please circle any of the listed symptoms that you are currently experiencing:

- | | | |
|---------------------|--|---------------|
| feeling poorly | lack of energy | fever/ chills |
| trouble seeing | trouble hearing | chest pain |
| shortness of breath | nausea | vomiting |
| diarrhea | weakness | rash |
| depression | difficulty with speech, memory, or cognition | |

Has anyone in your family ever been diagnosed with any of the following (since your last visit)? (Please circle if yes):

- | | | |
|---------------|----------------------|-----------------|
| Diabetes | Macular Degeneration | Retinal Disease |
| Glaucoma | Cataracts | Cancer |
| Heart Disease | Stroke | |

Do you drink alcohol? _____ If yes, how much? _____

Do you smoke? _____ If yes, how much? _____

Please provide our business office staff with your insurance card (s). A new HIPAA signature sheet is required to be signed as well every six months. We appreciate your patience. We are grateful to be entrusted in your care.