Name: ____ **Today's Date:** ____/____/______
Last, First Middle

Birthday: ____/____/______ **Age:** _______ **Sex:** ☐ **M** ☐ **F** **Social Security #:**_________________

Address: ___________________________ **City:** ______________ **State:** ______ **Zip:** _______

Home Phone #:__________________________**Cell Phone Number:** _____________________

Email Address :____

Employer: ________________________ **Occupation:**_____________ **Phone:**______________

Employers Address:_____________________________**City:**_______________**State:**_____**Zip:**________

Disabled: ☐ **Yes** ☐ **NO If Yes when did you become disabled:** _________________

Marital Status __________ **Spouses Name**____
Last, First Middle

Spouse Date of Birth ____/____/______ **Spouses Social Security #** ____________________________

Employer: ________________________ **Occupation:** ____________ **Phone:** ______________

Employers Address: ____________________________**City:** _______________**State:** _____**Zip:**_______

Emergency Contact Name: _________________________ **Address:** _______________________________

Phone Number: ____________________________ **Relationship:** _______________________

RESPONSIBLE PARTY (If Minor)

Name: ____________________________**Relationship to patient:** ________________________
Street Address: ______________________ **City:** _________________ **State:** ____ **Zip:** ______
Employer: ______________________________ **Work Phone:** ____________________________
Date of Birth: ____/_____/______**Social Security Number:** ___________________________

DATE YOU NOTICED VISION PROBLEMS: ____________________________________

REFERRING PHYSICAN NAME_______________________________**City:**_________________**State:**________________

PRIMARY CARE PHYSICAN NAME (Family Doctor) ______________________________

Address:______________________________**City:** _________________________**State:**_______

Signature on File, Assignment of Benefits, Financial Agreement
______________________________   ______________________ Patient Name *(print)*   Date of Birth
1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Norman D Radtke MD PSC, for services furnished me by Norman D Radtke MD PSC. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Norman D Radtke MD PSC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.
2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Norman D Radtke MD PSC, if possible or otherwise to me.
3. **RELEASE OF INFORMATION:** Norman D Radtke MD PSC may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Norman D Radtke MD PSC for reimbursement for services rendered, and (2) any health care provider for continued patient care. Norman D Radtke MD PSC may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.
4. **OTHER INSURANCE:** I understand that Norman D Radtke MD PSC maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Norman D Radtke MD PSC has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Norman D Radtke MD PSC if I belong to a plan that does not appear on the above mentioned list.
5. **NON-COVERED SERVICES:** I understand that Norman D Radtke MD PSC's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Norman D Radtke MD PSC to obtain necessary health care service plan authorizations.
6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Norman D Radtke MD PSC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Norman D Radtke MD PSC for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Norman D Radtke MD PSC. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Norman D Radtke MD PSC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.
______________________________   ______________________ Patient Signature or Authorized Party   Date

CHART ID ____________

NAME: ____________

TODAY'S DATE: ____________ BIRTHDATE: ____________

AGE: ________ SEX: ____________ RACE: ____________

A E J M

Referring Doctor: ____________

Primary Care Doctor: ____________

List any surgeries you have had (cataract, tonsils, appendix, etc.): ____________

Are you a new patient? Y or N (Please circle response)

Tech: ____________

1. Eyes: (circle all that apply)

vision loss	mucous discharge	excess tears/watering
blurred vision	watery discharge	light sensitivity
fluctuating vision	redness	eye pain or soreness
distorted vision	sandy/gritty feeling	eye or lid infection
loss of side vision	itching	lazy or crossed eyes
double vision	burning	tired eyes
dryness	foreign body sensation	drooping eyelids(s)

Brief description of your eye problem, when it began, and if its getting worse, better or fluctuates: ____________

Your History

Have you ever had or are you currently having any problems in the following areas?
If "Yes", please provide information.

2. General (fever, weight loss, etc.)
3. Ear, nose, throat (sinus, dry mouth, etc.)
4. Cardiovascular (heart, stroke, blood pressure, etc.)
5. Respiratory (asthma, bronchitis, etc.)
6. Gastrointestinal (stomach ulcers, etc.)
7. Genital, kidneys, bladder
8. Muscles, bones, joints (arthritis, etc.)
9. Skin (warts, acne, cancer, etc.)
10. Neurological (Multiple sclerosis, tumor, etc.)
11. Psychiatric (anxiety, depression, insomnia, etc.)
12. Endocrine (diabetes, thyroid dysfunction, etc.)
13. Blood/Lymph (high cholesterol, anemia, etc)
14. Allergic/Immunologic (hayfever, lupus, etc.)

Explanation of problem: ____________

Family History

Does anyone in your immediate family have any of the following? Circle all that apply and list family member.

Blindness	High blood pressure
Glaucoma	Kidney Disease
Arthritis	Lupus
Cancer	Stroke
Diabetes	Thyroid disease
Heart Disease	Other

Explanation of problem: ____________

Social History

Are you: Single Married Widowed Divorced

Employed Retired Other: ____________

Occupation: ____________

Do you:

Smoke, chew, or use tobacco products? Y or N

Packs per day or week? ____________

Drink alcohol? Y or N

Drinks per day or week? ____________

☐ No Change in ☐ ROS ☐ PFSH Since ____________ DR. ____________

Except ____________ DR. ____________

List medications: ____________

List eye medications: ____________

List allergies to medications ____________

COMMUNICATION CONFIDENTIALITY

PATIENT: ____________________________ DATE OF BIRTH: __________

I authorize the staff of Retina Vitreous Resource Center to discuss medical matters regarding my eye care with the below-listed persons:

NAME	**RELATIONSHIP**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

I authorize the staff of Retina Vitreous Resource Center to utilize the below information to contact me, leave messages, and/or mail necessary documents regarding my eye care:

HOME TELEPHONE: ________________________________ **YES / NO**

WORK TELEPHONE: ________________________________ **YES / NO**

CELLULAR PHONE: ________________________________ **YES / NO**

HOME ADDRESS: ________________________________ **YES / NO**

____

This document will expire one (1) year from the below date. At that time, my information will be required to be updated. No further contact will be made if this document is expired until my information has been updated and a new authorization has been completed.

______________________________________ ______________________________

SIGNATURE **DATE**

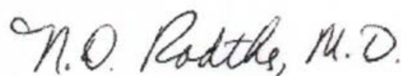
PAPERWORK COMPLETION

Because of the increasing burden on our office staff, effective January 1, 2015, there will be a charge for any paperwork filled out by our office staff. The rate will be $25 for the first 10 pages and an additional $2 per page thereafter. This charge is for all forms from TARC-3, Short-term Disability, FMLA (Family Medical Leave Act), Physician Statements of Disability, DMV (Department of Motor Vehicles), etc.

This fee will be due prior to any paperwork being faxed or mailed to the recipient along with a copy being sent to the patient for their records.

If you have any questions regarding the new policy being implemented, please contact Wesley Berry or Beverly Goatley for additional information at (502)636-2823 or (800)643-8197.

Sincerely,



Norman D. Radtke, M.D.
Director, Retina Vitreous Resource Center