MIDWEST RETINA CONSULTANTS, S.C.

COMPREHENSIVE NEW PATIENT INTAKE PACKET

1. Patient Information

Full Name: _____
Date of Birth: _____ Age: ____ Sex: ____
Address: _____
City/State/Zip: _____
Phone: _____ Cell: _____
Email: _____
Employer: _____ Occupation: _____
Marital Status: _____

2. Emergency Contact

Name: _____ Relationship: _____
Phone: _____

3. Insurance Information

Primary Insurance: _____
Secondary Insurance: _____
Subscriber Name: _____ DOB: _____
Member ID: _____ Group #: _____

4. Referring Physicians

Referring Doctor: _____
Primary Care Physician: _____
Other Specialists: _____

5. Eye History

☐ Macular Degeneration ☐ Diabetic Retinopathy ☐ Retinal Detachment
☐ Cataract ☐ Glaucoma ☐ Floaters ☐ Flashes
Other: _____

6. Medical History

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Cancer ☐ Thyroid Disease ☐ Autoimmune Disease
Other: _____

7. Surgical History

Please list prior surgeries:

_____

8. Medications

Medication | Dose | Frequency

_____
_____
_____

9. Allergies

☐ No Known Allergies
Medications/Foods: _____

10. Social History

Smoking: ☐ Yes ☐ No Alcohol: ☐ Yes ☐ No
Occupation: _____

11. Review of Systems

☐ Constitutional ☐ Eyes ☐ ENT ☐ Cardiovascular
☐ Respiratory ☐ GI ☐ GU ☐ Neurological
☐ Psychiatric ☐ Endocrine ☐ Hematologic ☐ Allergic

12. Dilating Eye Drops Consent

Dilating drops are used to enlarge the pupils for examination.
They may cause blurred vision and light sensitivity.
Driving may be affected.
Rare risks include angle-closure glaucoma.

I consent to dilation: ☐ Yes ☐ No

13. Medical Information Waiver

Voicemail permission: ☐ Yes ☐ No
Share with family: ☐ Yes ☐ No
Authorized person: _____

14. Signature

Patient Name: _____
Signature: _____ Date: _____