RETINA ASSOCIATES OF INDIANA

7621 West Jefferson Blvd Fort Wayne IN 46804
T: 260-436-2181 F: 260-436-2567
Adeel N. Khan, M.D., M.P.H., F.A.C.S.

Your first appointment will be at our office. We will not know what treatments are needed until Dr. Khan looks over everything and sees you at your appointment.

What to bring to your first visit:

- Insurance card(s)
- Driver's License
- Current medication list
- New patient paperwork

What to expect during your first visit:

- **You will need a driver** to drive you home after your office visit.
- During our first office visit, **both** of your eyes will be dilated.
- Your first appointment will be approximately **three hours long**.
- Any appointment after your first appointment will be approximately 90 minutes long.

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Common Disease We See

- Age Related Macular Degeneration
- Branch Retinal Vein Occlusion
- Central Retinal Vein Occlusion
- Diabetic Retinopathy
- Macular Hole/ Pucker
- Retinal Detachment
- Retinal Tear
- Retinal Vascular Disease
- Vitreous Hemorrhage

We take pride in providing the highest level of care to our patients in a very comfortable and personal atmosphere.

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Patient History Questionnaire

Name: ____ Date of Birth: ______________________
Referring Doctor: ________________________________ Primary Eye Doctor: _____________________
Family Physician: ________________________________ Reason for visit: _______________________

Current Complaints

	L	R
Decreased vision	L	R
Distorted vision	L	R
Blurred vision	L	R
Loss of side vision	L	R
Flashes	L	R
Floaters	L	R
Eye pain	L	R
Other:		

Eye Surgeries and Procedures — When

	L	R	When
Cataract	L	R	
Glaucoma	L	R	
Vitrectomy	L	R	
Scleral Buckle	L	R	
Laser	L	R	
Injections (Eyes Only)	L	R	
Photodynamic Therapy	L	R	
Other:			

Past Eye History

	L	R
Macular Degeneration	L	R
Glaucoma	L	R
Diabetic Retinopathy	L	R
Retinal Detachment	L	R
Eye Injury or trauma	L	R

if so please describe:

Family Eye Health

	Y	N	Who
Blindness	Y	N	
Macular Degeneration	Y	N	
Glaucoma	Y	N	
Retinal Detachment	Y	N	

Medical History

	Y / N
Anxiety	Y / N
Arthritis	Y / N
Asthma	Y / N
Cancer	Y / N
Cardiac Disease	Y / N
COPD	Y / N
Depression	Y / N
Diabetes	Y / N
Insulin / non insulin	
High Blood Pressure	Y / N
High Cholesterol	Y / N
Kidney Failure/ Dialysis	Y / N
Reflux	Y / N
Stroke	Y / N
Thyroid Disease	Y / N
Other:	

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Surgeries:

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Medications and Dosage:

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Allergies and Reaction

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Do you use illegal street drugs? Y / N
Do you drink alcohol? Y / N
Are you a current smoker? Y / N
If yes, how many years?
How many packs/ cigarettes per day?
Have you smoked in the past? Y / N
When did you quit?

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Patient Information

Patient Name: ____ **Date of Birth:** ______________________
(Last) (First) (MI) (Month / Date / Year)

Address:____
(Street) (City) (State) (Zip)

Social Security Number: _____________________ **E-Mail Address:** __________________________________

Home Phone: ___________________ **Cell Phone:** ___________________ **Preferred Contact:** Home Cell
Marital Status: Single / Engaged / Married / Widow
Where do you reside? Home / Nursing Facility / Rehabilitation Facility / Hospice

Emergency Contact Information

Name: ___________________________ **Phone Number:** ____________________ **Relationship:** ____________

Insurance Policyholder Information

Policyholder full name: __________________________________ **Relationship to Patient:** __________________
(Last) (First) (Mi)
Address (if different): ____
(Street) (City) (State) (ZIP)
Phone Number: _____________________ **Date of Birth:** ______________ **Social Security Number:** _____________

I Certify that I, and /or my dependent(s), have insurance coverage with ____________ and _______________. Assign directly to the physicians of Allen County Retinal Surgeons all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature of all insurance submissions.

Copays are due at check in at your appointment.

I understand also, that by signing, hereby authorizes consent to the physicians of Allen County Retinal Surgeons use my history along with any examination photographs for educational purposes, while ensuring my privacy is maintained. The physicians may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services.

____ ______________________
Signature of Patient or Parent / Legal Representative **Date**

____
Print Name of Patient or Parent / Legal Representative

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The Allen County Retinal Surgeons Notice of Privacy Practices have been provided to me. I understand I have the right to review the Notice of Privacy Practices prior to signing this document. By signing this document, acknowledge only that I have received or denied the Notice of Privacy Practices. Allen County Retinal Surgeons reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at time of next appointment.

I authorize the following person(s) minimal access (does not include copies of medical records) to my protected health information (PHI).
(Please include anyone outside of your medical team you want to have access to your information.)

Name	Phone Number	Relationship to you
______________________	___________________	_____________________
______________________	___________________	_____________________
______________________	___________________	_____________________

______________________________________ ____________________
Signature of Patient or Parent / Legal Representative Date

____
Print Name of Patient or Parent / Legal Representative

- ○ I would like a copy of the HIPAA Privacy Practices
- ○ I would not like a copy of the HIPAA privacy Practices

Financial Policy Agreement

In consideration of professional services rendered to patient below, I (we) agree to pay when billed customary charges for all services. I (we) understand that responsibility for the payment for services provided in this office is mine (ours), due and payable at the time of services rendered unless financial arrangements have been made. I (we) accept responsibility for payment of all services, which may be denied insurance coverage, to exclusion from covered services, noncompliance with preauthorization requirements, or any other reason for denial. If you have insurance, we will bill the provided information as a courtesy, but it does not relieve you of your responsibility for full payment of services.

______________________________________ ____________________
Signature of Patient or Parent / Legal Representative Date

____

Print Name of Patient or Parent / Legal Representative