PATIENT NAME: LAST FIRST MIDDLE **MALE OR FEMALE** (circle one)

ADDRESS:

ZIP CODE: **CITY:** **STATE:**

HOME PHONE #: **WORK PHONE #:** **CELL#:**

DATE OF BIRTH: **SOCIAL SECURITY NUMBER:**

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (circle one) SELF SPOUSE CHILD OTHER

PRIMARY CARE PHYSICIAN: **REFERRED BY:**

PATIENT'S EMPLOYER: **CITY:**

EMERGENCY CONTACT: **PHONE #:**

RESPONSIBLE (OR INSURED) PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

RESP. PARTY NAME: LAST FIRST MIDDLE

DATE OF BIRTH: **SEX:** (circle one) FEMALE MALE

HOME PHONE #: **WORK PHONE #:** **CELL#:**

SOCIAL SECURITY NUMBER:

RESPONSIBLE PARTY'S EMPLOYER : **CITY:**

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME

SUBSCRIBER'S NAME **ID/ POLICY#** **GROUP #**

GROUP NAME: **SUBSCRIBER DATE OF BIRTH:** **SUBSCRIBER'S SS#**

SECONDARY INSURANCE COMPANY NAME:

SUBSCRIBER'S NAME: **ID/ POLICY#** **GROUP#**

GROUP NAME: **SUBSCRIBER'S DATE OF BIRTH:** **SUBSCRIBER'S SS#**

PLEASE INITIAL AND SIGN BELOW:

_____ I understand that it is my responsibility to obtain any necessary referral or authorization from my insurance carrier. I also understand that my insurance plan may not cover the entire bill and that I will be financially responsible for any coinsurance, deductible, and non-covered service as determined by the insurance carrier. I also understand that if I do not have health insurance to cover this bill I will be financially responsible for any and all charges incurred.

AUTHORIZATION TO FILE INSURANCE: I hereby authorize SAM DAHR, M.D., to release to Medicare or other insurance carrier or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. This authorization includes release of information concerning HIV testing, diagnosis or treatment of **AIDS, AIDS** related conditions, drug or alcohol abuse, drug related conditions, and/or psychiatric/psychological diagnosis/treatment. Also, I authorize and request Medicare or any other insurance carrier to pay directly to the above named physician the amount due to me in my pending claim for medical or surgical services.

SIGNATURE:____

DATE:____

MEDICAL INFORMATION **RETINA CENTER OF OKLAHOMA**

NAME:___________________________________ **DATE:**_____________

Please carefully complete this form. Thank You.

List all current medications and dosage

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

List all medical problems, include when problems began.	**List all past surgeries, include year**
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	**List all known allergies (Drug and Food related)**
11	1.
12.	2.
13.	3.
14.	4.
15.	5.

Patient's Signature____ Date:__________

Sam S. Dahr, M.D.____ Date:__________

MEDICAL HISTORY QUESTIONAIRE
Retina Center of Oklahoma

NAME________________________________ TODAY'S DATE______________

Please carefully complete this form in its entirety. Thank You. BIRTH DATE_____________

1. THE MAIN REASON I MADE THIS APPOINTMENT IS:

____

____

____

2. REVIEW OF SYSTEMS

Do you have any problems in the following areas? If "**YES**," please explain.

	YES	NO	EXPLANATION OF PROBLEM
Constitutional Symptoms			
Fever	☐	☐	________________
Weight Loss	☐	☐	________________
Excessive Tiredness	☐	☐	________________
Eyes			
Loss of Vision	☐	☐	________________
Blurred Vision	☐	☐	________________
Bending of Straight Lines	☐	☐	________________
Blind Spots	☐	☐	________________
Loss of Side Vision	☐	☐	________________
Floaters	☐	☐	________________
Flashes of Light	☐	☐	________________
Double Vision	☐	☐	________________
Red Eye	☐	☐	________________
Light Sensitivity	☐	☐	________________
Eye Pain or Soreness	☐	☐	________________
Other	☐	☐	________________
Ears, Nose, Mouth, Throat			
Sinus Congestion	☐	☐	________________
Dry Throat/Mouth	☐	☐	________________
Ulcers in or around the Mouth	☐	☐	________________
Cardiovascular			
Chest Pain	☐	☐	________________
Angina	☐	☐	________________
Fluttering of Heart	☐	☐	________________
Fainting Spells	☐	☐	________________
Respiratory			
Shortness of Breath	☐	☐	________________
Frequent or Chronic Cough	☐	☐	________________
Wheezing	☐	☐	________________

2. Review of Systems (Continued)
*Do you have any problems in the following areas? If "**YES,**" please explain.*

Genitourinary

Genital Ulcers	☐	☐	______
Blood in Urine	☐	☐	______
Ankle Swelling	☐	☐	______

Musculoskeletal

Muscle Pain	☐	☐	______
Joint Pain	☐	☐	______
Jaw Pain when Chewing/Talking	☐	☐	______

Integument

Scalp Pain when Combing/Brushing	☐	☐	______
Change in Hair or Nails	☐	☐	______
Skin Rashes	☐	☐	______
Tick Bites	☐	☐	______
Loss of Skin Pigment	☐	☐	______
Lump in Breast	☐	☐	______

Neurolocilcal

Migraines	☐	☐	______
Frequent Headaches	☐	☐	______
Seizures	☐	☐	______
Loss of Strength (Paralysis)	☐	☐	______
Numbness in Hands or Feet	☐	☐	______
Memory Loss	☐	☐	______

Endocrine

Growth (Mass) in Neck or Throat	☐	☐	______
Increased Thirst	☐	☐	______
Sensitivity to Cold or Heat	☐	☐	______
Increased Acne	☐	☐	______
Change in Shoe or Hat Size	☐	☐	______
Unexplained Breast Lactation	☐	☐	______

Hematological/Lymphatics

Swollen Glands	☐	☐	______
Easy Bruising	☐	☐	______
Problem with Bleeding	☐	☐	______

Patient's Signature______________________________ Date:______________

Sam S. Dahr, M.D.______________________________ Date:______________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

I understand that, as part of my health care, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and plans for future care or treatment. I understand that this information serves as:

- A basis for my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and/or surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A means by which we carry out our health care operations.
- Appointment reminders or notifications.

I understand that I have been provided with opportunity to review a "NOTICE OF PRIVACY PRACTICES" that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the practice reserves the right to change our notice and practices. I understand that I have the right to request restrictions as to how my health care information may be used or disclosed to carry out treatment or to arrange payment. I understand that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

I understand that if I do not consent, you cannot provide services to me.

Oklahoma law requires that we advise you that **the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). It may also include mental health or other sensitive information.**

Signature:____ Date::____________
(of patient or legal representative)

Capacity of legal representative:______________________________________

STAFF ONLY: *If patient did not or could not acknowledge, please indicate why:*

INFORMED CONSENT FOR DILATED EYE EXAM/S AND CONSENT FOR FLUORESCEIN ANGIOGRAM/S

INFORMATION REGARDING DILATING EYE DROPS

1. Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

2. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

3. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

INFORMATION REGARDING DILATING FLUORESCEIN ANGIOGRAPHY

INDICATIONS AND ADMINISTRATION

4. Angiography is a diagnostic procedure in which a rapid sequence of photographs is taken to document the blood circulation of the retina/choroid. The dye is usually injected into a vein in the arm, forearm, or hand.

5. Since the fluorescein dye is a very bright yellow, the skin may appear jaundiced for a few hours and then the yellow color disappears. The dye is excreted through the kidney causing the urine to be bright yellow for 24-36 hours.

POSSIBLE COMPLICATIONS

6. Documented adverse reactions to the dyes which can occur include: nausea, headache, upset stomach, vomiting, light-headedness, fainting, hives, and itching.

7. Even more rarely, severe allergic reactions (anaphylaxis) or bronchospasm can occur and be life threatening**.** I have informed my physician of any allergies to foods, iodine, or medications. **By signing this consent, I certify that I have informed my physician if I have asthma.**

8. The leakage of the fluorescein dye out of the blood vessel is painful and every effort is made to prevent this from occurring.

FOR WOMEN:

9. Intravenous fluorescein is usually not administered to pregnant or nursing women, although there is no scientific evidence to suggest that it might harm the fetus or nursing babies.

By signing this consent, I certify to the best of my knowledge that I am not pregnant or nursing a baby.

PATIENT CONSENT

The above has been read by/to me. The nature of my eye condition and this procedure has been explained to me. The risks, benefits, alternatives, and limitations of the treatment have been discussed with me. All of my questions have been answered.

10. I hereby authorize Dr. Dahr and/or assistants to administer dilating eye drops. The eye drops are necessary to diagnose and/or treat my condition. This consent will be valid until I revoke it.

11. I hereby authorize Dr. Dahr and/or assistants to administer intravenous Fluorescein at intervals as needed for the purpose of performing angiography. This consent will be valid until I revoke it or my condition changes to the point that the risks and benefits of this medication for me are significantly different.

12. I hereby authorize and direct Dr. Dahr and/or assistants and/or their designees to provide such additional services as they may deem necessary and reasonable.

13. I understand that no guarantees of any kind regarding these procedures have been made to me.

14. I consent to the use of the above photographs and other materials for scientific purposes, provided my identity is not revealed by the pictures or the descriptive text accompanying them.

15. I have read and understand this consent form and my questions, if any, have been answered to my satisfaction.

______________________________ ____________________

Patient's Signature Date