montanaretina CONSULTANTS

MARC F. COMARATTA M.D.

Patient Information

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ SOCIAL SECURITY NUMBER: _____

PREFERRED PHONE: (___) _____ - _____ SECONDARY PHONE: (___) _____ - _____

EMAIL: _____ MARITAL STATUS: _____

EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: (___) _____ - _____ ADDRESS: _____

PRIMARY PHYSICIAN:

NAME: _____ OFFICE: _____

NAME: _____ OFFICE: _____

PHARMACY:

NAME: _____ CITY: _____

NAME: _____ CITY: _____

REFERRING PROVIDER

NAME: _____ OFFICE: _____

EXPLANATION FOR REFERRAL: _____

1940 WEST DICKERSON ST., SUITE 103 | BOZEMAN, MT 59718
PHONE: 406-284-2370 | FAX: 406-284-2372

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MARC F. COMARATTA M.D.

PRACTICE LIMITED TO DISEASES OF THE RETINA - VITREOUS

PRIVACY AND FINANCIAL POLICIES

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____

PLEASE READ AND INITIAL THE FOLLOWING OFFICE POLICIES OF MONTANA RETINA CONSULTANTS

_____I request that PAYMENT of Medicare or other Insurance benefits be made directly to Mark R. Comaratta, MD or Marc F. Comaratta, MD. I CONSENT to the release of medical information to the Centers of Medicare and Medicaid services and other Insurance companies during treatment from Montana Retina Consultants.

_____I understand that I am responsible for any balance not covered by Insurance. I agree to pay any reasonable collection costs and attorney fees if my account is placed in collection for non-payment.

_____I understand that patients may be responsible for a $50.00 fee that cannot be billed to insurance and must be paid on or before the next scheduled appointment should I not attend a scheduled appointment or do not provide 24-hour's notice to change a scheduled appointment.

_____I understand that information related to my examinations at Montana Retina Consultants may be needed by outside medical offices for continuance of care, or to insurance companies to authorize payment of claims. I hereby authorize Montana Retina Consultants to release my information including the billing, condition, and treatment to parties covered under the Continuity of Care guidelines.

_____I hereby consent to receive text messages at the number provided, including appointment reminders. Standard message and data rates may apply.

AUTHORIZATION TO RELEASE INFORMATION

I give my permission to release information regarding my medical condition and treatment to the following non-medical persons:

Name:_____ Relationship:_____ Phone:_____
Name:_____ Relationship:_____ Phone:_____
Name:_____ Relationship:_____ Phone:_____
Name:_____ Relationship:_____ Phone:_____

I acknowledge that I have been informed of Montana Retina Consultant's notice of Privacy and Financial Policies, and upon request, a copy shall be made available for my review at any time. I understand that this form shall stay in effect until changed or revoked by myself in writing.

Signature of Patient/Guardian: _____ Date:_____

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Consultants
www.montanaretinaconsultants.com

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Bozeman, MT 59718
Phone: 406-284-2370
Fax: 406-284-2372

AUTHORIZATION TO BILL CREDIT/DEBIT CARD

Today's Date: _____

I authorize Montana Retina Consultants to charge my credit/debit card account the entire balance due immediately after insurance determination or 60 (sixty) days have passed whichever occurs first.

Printed Name: _____

Signature: _____

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PATIENT PORTAL

For easy access to your medical records online, please answer the following questions and return this form to Reception.

All information provided is confidential and this form will be returned to you before you leave our office. Information provided will be used for registration purposes only.

Please answer the following questions:

What city were you born in?

What state were you born in?

What was the name of your best friend growing up?

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PATIENT REVIEW OF SYSTEMS/MEDICAL HISTORY

PATIENT NAME: DATE OF BIRTH:

MEDICAL HISTORY-PATIENT EYE (CIRCLE EYE) HOW LONG

PLEASE CHECK ALL THAT APPLY:

☐RED EYES **L R** ☐SHADOW/CURTAIN/VEIL DISTORTION **L R** ☐EYE INJURY **L R**

☐LOSS OF VISION: SUDDEN/GRADUAL **L R** ☐FLASHES **L R** ☐GLASSES/CONTACTS **L R**

☐DRYNESS/WATERING **L R** ☐HALOS **L R** ☐EYE DISEASE **L R**

☐IRRITATION/EYE PAIN **L R** ☐LAZY EYE **L R** ☐EYE SURGERY **L R**

☐FLOATERS **L R** ☐GLAUCOMA **L R** ☐CROSSED EYES **L R**

☐DOUBLE VISION **L R** ☐DISCHARGE **L R** ☐OTHER_____

MEDICAL HISTORY-PATIENT

PLEASE CHECK ALL THAT APPLY:

☐HIGH BLOOD PRESSURE CONTROLLED: ☐YES ☐NO

☐DIABETES TYPE:_____ AIC:_____ INSULIN DEPENDENT Y/N CONTROLLED Y/N

☐HEART DISEASE ☐HIGH CHOLESTEROL

☐HEART ATTACK ☐PACEMAKER/DEFIBRILLATOR

☐CHEST PAIN/ANGINA LAST EPISODE:_____ RELIEVED BY:_____

☐HEART MURMUR ☐PNEUMOCOCCAL VACCINE Y/N WHEN: _____

☐ARRHYTHMIA ☐ INFLUENZA VACCINE Y/N WHEN:_____

☐HEART SURGERY ☐HEART VALVE DISORDER LAST EPISODE:_____

☐HEART FAILURE

☐STROKE WHEN:_____ ☐PERIPHERAL VASCULAR DISEASE

☐TIA/MINI STROKES

☐BLEEDING DISORDERS ☐SEIZURES

☐PNEUMONIA ☐ANEMIA

☐FEVER/WEIGHT LOSS ☐ASTHMA/EMPHYSEMA

☐ON BIRTH CONTROL ☐PREGNANT HOW FAR ALONG?:_____

☐HIV ☐STD TYPE:_____

☐HEPATITIS TYPE:____ ☐TUBERCULOSIS/TB WHEN TREATED:_____

☐SICKLE CELL TRAIT ☐BLOOD TRANSFUSION WHEN:_____

☐KIDNEY DISEASE ☐KIDNEY FAILURE/DIALYSIS TYPE:_____

☐CANCER ☐ARTHRITIS

☐BACK PROBLEMS ☐MIGRAINES

☐HEADACHES ☐DEPRESSION

☐ANXIETY ☐GASTRIC REFLUX

☐STOMACH PROBLEMS ☐PSYCHIATRIC TREATMENT

☐BRONCHITIS ☐DIFFICULTY SWALLOWING

MEDICAL HISTORY-FAMILY (INDICATE FAMILY MEMBER)

☐HEART DISEASE _____ ☐MACULAR DEGENERATION _____

☐GLAUCOMA _____ ☐DIABETES _____

☐RETINAL DETACHMENTS _____ ☐LAZY EYE _____

☐HIGH BLOOD PRESSURE _____ ☐OTHER_____

☐BLINDNESS _____

☐FAMILY OR PERSONAL HISTORY OF PROBLEMS WITH ANESTHESIA _____

PATIENT REVIEW OF SYSTEMS/MEDICAL HISTORY

ALLERGIES

☐MEDICATIONS: _____

☐FOODS: _____

☐LATEX: _____

☐ADHESIVES (BANDAIDS, TAPE) ☐NONE

CURRENT MEDICATIONS-INCLUDE OVER-THE-COUNTER AND EYE DROPS/MEDICATIONS

MEDICINE NAME (OR PROVIDE A COPY)	DOSE	HOW OFTEN DO YOU TAKE IT?

PREVIOUS SURGERIES

PLEASE PROVIDE TYPE OF SURGERY AND YEAR

SOCIAL HISTORY

WHAT IS YOUR TOBACCO USE HISTORY?

USES TOBACCO: ☐CURRENTLY ☐NEVER ☐FORMERLY

TOBACCO TYPE: ☐CIGARETTES ☐PIPE ☐CHEWING ☐CIGAR ☐SNUFF ☐SMOKELESS

AMOUNT PER DAY:_____ (PACKS, OUNCES,CIGARS PIPES UNITS) NUMBER OF YEARS:_____

PASSIVE SMOKE EXPOSURE: ☐YES ☐NO

WHAT IS YOUR ALCOHOL USE HISTORY?

DRINKS ALCOHOL: ☐YES ☐NO ☐FORMERLY

FREQUENCY: ☐OCCASSIONALLY/SOCIALLY ☐1 TO 2 DRINKS DAILY ☐3+ DRINKS DAILY

DRINKS CAFFEINE: ☐YES ☐NO

RECREATIONAL DRUG USE: TYPE_____FREQUENCY_____