Pine R. Pine M.D., LTD
PH: (217)348-0221 FAX: (217)345-1380 | aocharleston@aocharleston.com

PATEINT INFORMATION

PATIENT'S FIRST NAME | MIDDLE NAME | LAST NAME

STREET ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE | WORK PHONE | CELL/ALTERNATE PHONE

SOCIAL SECURITY # | BIRTHDATE | RACE | MARITAL STATUS | GENDER

PATIENT'S OCCUPATION | PATIENT'S EMPLOYER

MOTHER'S FULL NAME (IF MINOR) | FATHER'S FULL NAME (IF MINOR)

May we call you at the number you provided?

Home #: Yes No Cell #: Yes No Work #: Yes No

May we leave a voicemail at the provided number?

Home #: Yes No Cell #: Yes No Work #: Yes No

May we leave a message with the person answering our call?

Home #: Yes No Cell #: Yes No Work #: Yes No

I give my permission to release confidential health information to the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Do you have a Power of Attorney for medical purposes? If yes, please provide:

Name: _____ Relationship: _____

Address: _____ Phone: _____

Please notify the office in writing of any changes to the above information.

Ryan R. Pine M.D., LTD

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Thank you for choosing Advanced Ophthalmology to participate in your healthcare. As a patient in our practice, it is important that you are aware of our financial policies and conditions of care and service.

Medical and Surgical Care/Services/Treatment: I acknowledge that the practice of medicine is not an exact science and that no guarantee has been made as the result of the care and/or services/treatments performed. This includes acknowledging that other known or yet undetected health conditions and/or outcomes of my care and may result in complications and/or adverse reactions that could not have been anticipated and/or prevented. I acknowledge that I may be asked for additional consent for some procedures and will take responsibility/initiate/participate in discussions about the risks, benefits, and alternatives prior to consenting and/or participating in diagnostic and therapeutic testing and/or care. I acknowledge that I have both Rights and Responsibilities and will seek information and/or explanations for any topics I do not fully understand or need more information about standard Health System signage and/or written materials that I have access to as an outpatient.

Insurance Filing: Prior to your appointment, please call your insurance carrier to confirm that Dr. Ryan Pine is a provider in your specific plan/network. Some insurance plans require a referral or authorization from your primary care physician prior to seeing a specialist. We ask that you request such a referral or authorization, or you may be responsible for all charges. Advanced Ophthalmology will file your claim in a timely manner, provided that we have the correct insurance on file. If the insurance does not pay within 60 days, the balance will be turned over to the patient.

Payment Policy: All co-pays are due at the time of service. If you do not have insurance or you do not have your insurance card, we will require $100.00 at the time of your appointment. Payment plans require approval to appointment. In order to be of service to all patients, we ask that you inform us of cancellations 24 hours prior to your appointment. There could be a charge of $35 for late cancellation or no-show appointments and $200 for scheduled surgeries cancelled less than 2 weeks prior to surgery.

Medical Records and Forms: If you require a copy of your medical records, a fee may be charged to offset our cost. The fee is $20 for the first 10 pages plus .50 for each additional page. Government regulations limit but allow for these fees and require us to obtain a Medical Records Release Authorization form prior to the release of records. If you require FMLA, disability, or other forms to be completed, a fee of $25 will be charged. All fees are payable at the time of request.

Collection Policy: If your account becomes delinquent and you have made no attempt to pay your bill or contact us, the account will be turned over to a collection agency or attorney. In that event, your responsible for all collection cost including attorney fees, court costs, and interest.

I authorize Advanced Ophthalmology, office of Dr. Ryan Pine, to release information for benefits on my behalf for services rendered. I authorize disclosure of medical information to the extent necessary to determine liability for payment and to obtain reimbursement as well as disclose to other physicians as needed for consulting. I request that payment from my insurance company, Medicare, or Medicaid be made directly to Ryan R. Pine, M.D. LTD.

Health Information Privacy Notice: I acknowledge that I have the right to obtain a copy of the Health Information Privacy Notice at any time, which describes the uses and disclosures of my protected health information by Advanced Ophthalmology and informs me of my rights.

I hereby authorize Advanced Ophthalmology to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked**.

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ **Date:** _____

WITNESSED BY: _____

Advanced Ophthalmology

Patient Intake Form

Please Complete As Accurately As Possible

Name:		DOB:	
Primary Care Physician			
Referring Physician			
Pharmacy		City	

Tobacco Use	Yes	No	Former	How Often:	
Alcohol Use	Yes	No	Former	How Often:	
Drug Use	Yes	No	Former	How Often:	

Allergies

Food	Drug	Reaction	Severity

Family History

Description	Relationship To You	Living/Deceased	Approximate Age	Comments
Blindness				
Cancer				
Cataracts				
Diabetes				
Glaucoma				
Heart Disease				
Kidney Diesase				
Lazy Eye				
Macular Degeneration				
Migraines				
Retinal Detachment				
Stroke				
Thyroid Disease				
Other				

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Patient Intake Form

Please Complete As Accurately As Possible

Ocular Surgeries

General Surgeries

Current Systemic Medications	Dosage

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Patient Intake Form

Please Complete As Accurately As Possible

Ocular History	Affected Eye		
Overall Healthy	Right	Left	Both
Amblyopia(Lazy Eye)	Right	Left	Both
Astigmatism	Right	Left	Both
Bells Palsy	Right	Left	Both
Blunt Trauma/Injury	Right	Left	Both
Cataracts	Right	Left	Both
Corneal Abrasion	Right	Left	Both
Contact Lens Wear	Right	Left	Both
Diabetic Retinopathy	Right	Left	Both
*Treatments			
*Lasers	Right	Left	Both
*Injections	Right	Left	Both
Dry Eyes	Right	Left	Both
Esotropia(Eyes Turning In)	Right	Left	Both
Exotropia(Eyes Turning Out)	Right	Left	Both
Glaucoma	Right	Left	Both
Hyperopia(Far Sighted)	Right	Left	Both
Iritis	Right	Left	Both
Keratoconus	Right	Left	Both
Macular Degeneration - Dry	Right	Left	Both
Macular Degeneration - Wet	Right	Left	Both
*Injections			
*Eyela	Right	Left	Both
*Avastin	Right	Left	Both
*Lucentis	Right	Left	Both
Myopia (Near Sighted)	Right	Left	Both
Retinal Detachment	Right	Left	Both
Retinal Tear	Right	Left	Both
Other	Right	Left	Both
	Right	Left	Both
	Right	Left	Both
	Right	Left	Both
	Right	Left	Both

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Patient Intake Form

Please Complete As Accurately As Possible

AIDS	Yes	No
Alzheimers Disease	Yes	No
Anemia		
*Iron Deficiency	Yes	No
*Pernicious	Yes	No
Anxiety Disorder	Yes	No
Arthritis		
*Osteoarthritis	Yes	No
*Rheumatoid	Yes	No
Bleeding Disorder	Yes	No
Cancer, Type:	Yes	No
Carotid Artery Disease	Yes	No
Cardiovascular Disorder	Yes	No
Carpal Tunnel Syndrome	Yes	No
Cerebral Palsy	Yes	No
Chronic Kidney Disease	Yes	No
Cirrhosis of Liver	Yes	No
Congestive Heart Failure	Yes	No
COPD	Yes	No
Deep Vein Thrombosis	Yes	No
Dementia	Yes	No
Depression	Yes	No
Diabetes	Yes	No
*Age Of Onset_____		
*Type 1- Insulin Dependent	Yes	No
*Type 2 - Non-Insulin Dependent	Yes	No
*Type 2 - Insulin Dependent	Yes	No
*Average Blood Sugar_____		
*Last Hgb A1C%_____		
Diabetic Kidney Complications	Yes	No
Diverticulosis	Yes	No
Downs Syndrome	Yes	No
Eczema	Yes	No
Fibromyalgia	Yes	No
Gout	Yes	No
Hard of Hearing	Yes	No
Hepatitis		
*Type A	Yes	No
*Type B	Yes	No
*Type C	Yes	No

Herpes Simplex(Cold Sores/Chicken Pox)	Yes	No
Herpes Zoster (Shingles)	Yes	No
Hypercholesterolemia	Yes	No
Hypertension	Yes	No
Juvenile Rheumatoid Arthritis	Yes	No
Lupus	Yes	No
Lyme Disease	Yes	No
Melanoma of Skin	Yes	No
Marfans Syndrome	Yes	No
Migraine Headaches	Yes	No
Mitral Valve Prolapse	Yes	No
MRSA Infection	Yes	No
Multiple Sclerosis	Yes	No
Myotonic Dystrophy	Yes	No
Osteoporosis	Yes	No
Parkinsons Disease	Yes	No
Pituitary Adenoma	Yes	No
Pseudotumor Cerebri	Yes	No
Psoriasis	Yes	No
PulmonaryEmbolism	Yes	No
Rosacea	Yes	No
Sarcoidosis	Yes	No
Schizophrenia	Yes	No
Seasonal Allergies	Yes	No
Seizure Disorder	Yes	No
Sickle Cell Disease	Yes	No
Sinusitis	Yes	No
Sjogrens Syndrome	Yes	No
Sleep Apnea	Yes	No
Stroke	Yes	No
Temporal(Giant Cell) Arteritis	Yes	No
Thyroid Disease		
*Graves Thyroid Disease	Yes	No
*Hyperthyroidism	Yes	No
*Hypothyroidism	Yes	No
TIA(Mini Stroke)	Yes	No
Tobacco Use	Yes	No
Torticollis	Yes	No
Ulcerative Colitis	Yes	No
Vertigo	Yes	No

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Review of Systems

Please Check/Circle All That Apply Now

Eyes

- Previous Surgery
- Contact Lens
- Pain
- Double Vision
- Glaucoma
- Cataracts
- Macular Degeneration
- Dry Eyes
- Flashes
- Floaters

Ear, Nose, and Throat

- Hard Of Hearing
- Ringing In Ears
- Vertigo

Cardiovascular

- Chest Pain
- Dizziness
- Fainting Spells
- Shortness of Breath
- Irregular Heart Beat
- Difficulty Lying Flat

Constitutional

- Fatigue/Weakness
- Weight Gain/ Loss

Respiratory

- Cough
- Wheezing
- Asthma

Gastrointestinal

- Heartburn
- Nausea/Vomiting
- Jaundice/Hepatitis - A B C

Genito-Urinary

- Pain/Difficulty Urinating
- Blood in Urine
- History of Kidney Stones
- History of STD's

Psychiatric

- Anxiety/Depression
- Mood Swings
- Difficulty Sleeping

Endocrine

- Increased Thirst
- Increased Hunger
- Increased Urination
- Increase Sweating

Blood/Lymph nodes

- Easy Bruising
- Prolonged Bleeding
- Heavy Aspirin Use

MusculoSkeletal

- Stiffness
- Arthritis – Osteo, Rheumatoid
- Joint Pain/Swelling

Skin

- Rash/Sores
- Hives/Eczema

Neurological

- Seizures
- Weakness/Paralysis
- Numbness
- Tremors