Who referred you to our office _____

Date: _____

Account Number: _____

Jeffrey M. Gosslee M.D., APMC

Retina Specialists

725 N Ashley Ridge Loop, Ste 400 Shreveport, LA 71106

Phone: (318) 841-8844

Patient Registration Form

Please Print

First Name _____ Middle Initial _____ Last Name _____ Sex_____

Mailing Address _____

Street Address (if different from mailing) _____

Employer Name and Address _____

Home Phone _____ Cell Phone_____ Work Phone _____

Preferred Method of Contact_____ Date of Birth _____ Age_____

Social Security Number _____ Marital Status (Please Circle) Married Single Widowed Divorced Partner

Email address for Patient Portal enrollment, patient education and reminders _____

__ I do not have an email address. __ I have an email address but I decline to participate at this time.

Emergency Contact Name: _____ **Relation _____ Phone _____**

Is today's visit related to a work or automobile injury? Yes / No

Medicare Patients: Are you or your spouse covered by an employer group health plan? Yes / No

Disclosures of health information will only be made with your written consent. With whom would you like us to share your health information? _____No one

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

IF YOU ARE A DEPENDENT ON AN INSURANCE POLICY, PLEASE PROVIDE THE FOLLOWING FOR THE PRIMARY POLICY HOLDER:

Name: _____ DOB: _____ SS#_____ Relation to patient_____

Is Patient in a Skilled Nursing Facility? Yes or No Is Patient in a Rehab Facility? Yes or No

IF YES, PLEASE PROVIDE: FACILITY NAME: _____

ADDRESS: _____ PHONE #: _____

I agree that Dr. Jeffrey M. Gosslee, Retina Specialists may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for the purpose of treatment.

Signature: _____ Date: _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MY PHYSICIAN, Jeffrey M. Gosslee M.D., APMC, OR SUPPLIER FOR SERVICE DESCRIBED. I AGREE IF AN INSURANCE CHECK IS MAILED TO ME, I WILL IMMEDIATELY FORWARD TO RETINA SPECIALISTS TO BE POSTED. I understand that I am financially responsible for all charges incurred. We will file your claim to the insurance on file. Dr. Gosslee is contracted with your insurance plan to collect a co-pay, deductible or co-insurance at the time of service.

_____

SIGNED (INSURED OR AUTHORIZED PERSON)

Primary Pharmacy:

PHARMACY NAME: _____

ADDRESS: _____

_____

PHONE #: _____

FAX#: _____

Secondary Pharmacy: (IF APPLICABLE)

PHARMACY NAME: _____

ADDRESS: _____

_____

PHONE #: _____

FAX#: _____

WHAT IS THE REASON FOR YOUR VISIT TODAY (circle all that apply)

Blurred Vision, Blind Spots, Diabetic Eye Exam, Distorted Vision, Eye Pain, Flashes of Light, Floaters, Vision Loss, Trauma, Other: _____

Drug Allergies and Reactions: _____

CURRENT PRESCRIPTION & OVER THE COUNTER MEDICATION/SUPPLEMENT LIST

Name: _____ DOB: _____ Date: _____

DRUG NAME (PLEASE PRINT)	**DOSAGE**	**Route (Oral, Nasal, IM, Topical, Suppository)**

Surgery/Procedure/hospitalization	Date

Please list all general surgeries and/or procedures and hospitalizations and the approximate date.

Eye History

Please list all past eye surgeries and/or procedures and the approximate date.

Eye surgery/procedure	Date

Medical History / Review of Systems

Name:_____ DOB:_____ Today's Date: _____

Do you smoke? ____ If so, How many packs a day_____ How Long _____ Do you drink alcohol? _____ If so, how often? _____

Have you had any recent falls? Yes or No If yes, Did you obtain any injuries? Yes or No *Do you exercise regularly? Type of exercise_____

Personal medical history	**Check if YES**	**Insulin Dependent**		**Type 1**	**Type 2**	**Year Diagnosed**	**Blood Sugar**	**Last A1C**
Constitutional:		YES	NO					
Shortness of Breath		**Urinary:**				**Neurologic:**		**Check if Yes**
Palpitations		Frequency				Weakness		
Edema		Incontinent				Headaches		
Weakness/Lack of energy		Hematuria				Seizures		
Confusion		Dysuria				Trouble with balance		
Dizziness		Urgency				Numbness		
Fever		Erectile Dysfunction				Loss of Memory		
Chills		**Musculoskeletal:**				Stroke(s)		
Insomnia		Joint pain				Tremors		
HEENT:		Arthritis				**Endocrinology:**		
Blurred vision		Back pain				Hypothyroidism		
Double vision		Muscle aches				Hyperthyroidism		
Glaucoma		Tenderness				Excess thirst		
Cataracts		Gout				Diabetes		
Hearing difficulty		**Dermatology:**				Kidney failure		
Decrease in vision		Rash				**Hematology:**		
Macular Degeneration		Itching				Bleeding		
Respiratory:		Eczema				Anemia		
Wheezing/Asthma		Psoriasis				Clotting problems		
Shortness of Breath		Shingles				Easily bruising		
COPD		Skin cancer				**Cardiovascular:**		
Cough		**Urinary:**				Chest pain		
Sinuses/Seasonal Allergies		Frequency				Palpitations		
Digestive System:		Burning				Low blood pressure		
Abdominal pain		Hesitancy				High blood pressure		
Indigestion		Infections				High cholesterol		
Acid reflux Nausea		Blood in urine				**Psychiatric:**		
Ulcers		Erectile dysfunction				Depression		
Gallstones		Amputation				Anxiety		
Constipation						Dementia		

I have been provided the opportunity to read **Jeffrey M. Gosslee, MD** Notice of Privacy Policy. I give my permission to use my personal health information where you have authorized us to do so. This signature page will remain in the patient's chart as record of acceptance and the Notice of Privacy Policy is for the patient (or patient's representative) to keep for his/her records.

*You may receive a copy of our Notice of Privacy upon request at check-in.

☐

- By checking the box above, I have declined to accept the Notice of Privacy.

Patient's Name (PRINT): _____

Signature (Patient or Authorized Representative): _____

Relationship to Patient if other than Self: _____

Address: _____

Telephone Number: _____

Date: _____

PLEASE INFORM DR. GOSSLEE AND STAFF OF ALL THE PHYSICIANS YOU ARE CURRENTLY SEEING

SPECIALTY	PHYSICIAN NAME	ADDRESS	PHONE NUMBER

1. **Ophthalmologist / Optometrist:** _____
2. **Cardiologist:** _____
3. **Internist:** _____
4. **Podiatrist:** _____
5. **Endocrinologist:** _____
6. **Nephrologist:** _____
7. **Vascular Consultant:** _____
8. **Urologist:** _____

Dr. Jeffrey M. Gosslee, M.D., A.P.M.C.

725 North Ashley Ridge Loop, Suite 400

Shreveport, LA 71106

(318) 841-8844

INFORMATION REGARDING DILATING EYE DROPS

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.

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, you should carefully consider making arrangements not to drive yourself. Some patients may experience the effects of dilation from 6 to 72 hours. For others, the effects may wear off sooner.

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.

I hereby authorize Dr. Jeffrey M. Gosslee, and/or one of his assistants to administer dilating eye drops. The eye drops are necessary to evaluate my condition.

_____ _____

Patient (or person authorized to sign for patient) Date

_____ _____

Witness Date

IMPORTANT INFORMATION REGARDING INSURANCE COVERAGE FOR LAB TESTING

Throughout your treatment, Dr. Gosslee may periodically order lab tests. Some tests will be ordered from Quest or Lab Corp, but we often send our labs to Clinical Pathology 725 North Ashley Ridge Shreveport, LA 71106.

If your insurer has designated another lab besides Clinical Pathology, please let us know so that in the case labs are ordered, we can provide you with an order to take to the lab designated by your insurance plan. Failure to use the lab company specified by your insurance could result in hundreds of dollars of out of pocket expense to the patient. The lab company will bill you for any balance left unpaid by your insurance plan.

_____ _____

Patient/Guardian Signature Date

_____ _____

Witness Date