Jeffrey M. Gosslee M.D, APMC Retina Specialists

Who referred you to our office _____

Date Completed: _____

Account Number: _____

Jeffrey M. Gosslee M.D., APMC

Retina Associates of Louisiana

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 _____

Physical 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 and announcements: _____

__ 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 _____**

Preferred Language _____ Ethnicity ___ Hispanic or Latino ___ Non-Hispanic or Latino

Race (Please Check) __ Caucasian / White ___Black or African American ___ Asian ___Multiracial

_____American Indian or Alaska Native _____Native Hawaiian or Other Pacific Islander

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

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

Who May we discuss your health information with? ____ No One other than self

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

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

Name: _____ Social Security Number: _____

Date of Birth: _____ Relationship 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 treatment of purposes.

Signature: _____ Date: _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN, Jeffrey M. Gosslee M.D., APMC OR SUPPLIER FOR SERVICE DESCRIBED. I understand that I am financially responsible for all charges incurred regardless of payment by my insurance company or companies.

_____

SIGNED (INSURED OR AUTHORIZED PERSON)

Primary Pharmacy:

PHARMACY NAME: _____

ADDRESS: _____

_____

PHONE #: _____

FAX#: _____

Secondary Pharmacy:

PHARMACY NAME: _____

ADDRESS: _____

_____

PHONE #: _____

FAX#: _____

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CURRENT PRESCRIPTION & OVER THE COUNTER MEDICATION/SUPPLEMENT LIST

Name: _____ DOB: _____ Date: _____

Drug Allergies and Reactions: _____

_____

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

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Surgical history:

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

Surgery/Procedure/hospitalization	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

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

Do you smoke? ____ If So, How many packs a day_____ How Long _____

Have you had any recent falls? Yes or No If yes, Did you obtain any injuris? Yes or No

Do You Consume Alcohol? _____ If So, how often _____ How Much _____

Do you exercise regularly? _____ What type of exercises _____

Personal medical history	**Check if YES**	**Insulin Dependent**		**Type 1**	**Type 2**	**Year Diagnosed**	**Blood Sugar**	**Last A1C**
Endocrine: Diabetes		YES	NO					

Hypothyroidism		**Digestive System**	**Check if Yes**	**HEENT**	**Check if Yes**
Hyperthyroidism		Abdominal Pain		Blurred Vision	
Heat Intolerance		Acid Reflux		Double Vision	
Excess Thirst		Change in Bowel		Glaucoma	
Renal Failure		Nausea		Cataracts	
Constitutional:		Gall Stones		Distortion Vision	
Shortness of Breath		**Neurologic:**		Decrease in Vision	
Palpitations		Weakness		Macular Degeneration	
Edema		Headaches		Difficulty Hearing	
Weakness		Seizures		**Urinary**	
Confusion		Trouble with Balance		Frequency	
Dizziness		Numbness		Incontinent	
Fever		Loss of Memory		Hematuria	
Chills		Headaches		Dysuria	
Insomnia		Strokes		Urgency	
Lack of Energy		Tremors		Erectile Dysfunction	
Cardiovascular:		**Respiratory**		Infection	
Chest Pain		Wheezing/Asthma		Kidney Stones	
Hypertension		Shortness of Breath		**Hematology:**	
High Cholesterol		COPD		Bleeding	
Swelling of Feet		Cough		Anemia	
Low Blood Pressure		Sinuses/Seasonal Allergies		Clotting Problems	
High Cholesterol		**Dermatology:**		Easily Bruising	
Heart Disease		Rash		Risk Factors for HIV	
Hypotension		Itching		**Psychiatric:**	
A - Fib		Eczema		Depression	
Musculoskeletal:		Psoriasis		Anxiety	
Joint Pain / Swelling		Shingles		Dementia	
Muscle Aches		Skin Cancer		Hallucinations	
Ambulatory with Assistance					
Back Pain					
Amputation					

Jeffrey M. Gosslee M.D, APMC Retina Specialists

I have been given the opportunity to read **Jeffrey M. Gosslee, MD** Notice of Privacy Policy concerning how my personal information may be used. I give my permission to use my personal information in accordance with this policy. This signature sheet will remain in the patient's chart as record of acceptance and the Notice of Privacy Practice 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. Thank You.

☐

- 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 as may be designated 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

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IMPORTANT INFORMATION REGARDING INSURANCE COVERAGE FOR LAB TESTING

Important information for all patients.

After your initial visit and on subsequent visits throughout your treatment, Dr. Gosslee may need to order a number of lab tests to evaluate your health. Some tests will be ordered from the usual group of "reference laboratories" with which you may be familiar (e.g. Quest, LabCorp, etc.) For any tests ordered from the lab. In this office, we are set up to send our labs to Clinical Pathology 725 North Ashley Ridge Shreveport, LA 71106.

If your insurer has designated some other lab than the above for you to use, it may well be financially to your advantage to go directly to your own designated lab to have this portion of your lab work done. Lab testing is inevitably expensive, often running several hundred dollars or more. The designated lab may be reimbursable at 100%. The non-designated lab may be reimbursable at only 70-80%, perhaps less a deductible. Depending on the provisions of your policy, it may not be reimbursable at all if the blood work is ordered by a physician who is out of network.

WE CANNOT KNOW EACH AND EVERY INDIVIDUALS HEALTH INSURANCE POLICY, AND ITS SPECIFIC BENEFITS, PROVISIONS, AND EXCLUSIONS. THIS IS YOUR RESPONSIBILITY. Knowing your policy in this and other regards can maximize your reimbursements, and greatly reduce your out of pocket medical expenses.

Please Note:

If your insurance company denies payment, it will be your responsibility to pay for services that are not covered by your insurance company to help in the evaluation.

_____ _____

Patient/Guardian Signature Date

_____ _____

Witness Date