

ALASKA RETINAL CONSULTANTS

5600 B Street

ANCHORAGE, ALASKA 99518

907-561-1530 FAX: 907-561-2611

Scott A Limstrom, MD David S Zumbro, MD Matthew G Guess, MD Chad Bouchard, DO

Welcome to Alaska Retinal Consultants

You are receiving this letter because you have been referred to our clinic for an evaluation of your retina. We welcome the privilege of participating in your care and will do everything possible to make your experience with us a positive one.

Pre-Appointment Preparations

In this packet you will find **Demographics**, **Release of Information**, and **Medical History Questionnaire** forms. We ask that you complete and return these forms to **Alaska Retinal Consultants** prior to your appointment. Completing your new patient packet beforehand will help save you time on the day of your appointment.

If you are unable to return the packet before your appointment, please have it with you on appointment day.

You can return your completed packet by one of these means:

- **Email:** Scheduling@alaskaretina.com
- **Fax:** (907) 561-2611 (Attn: Admin)
- **Mail:** 5600 B Street, Anchorage, AK 99518 (Attn: Admin)

If you have any difficulty completing these forms, please fill them out to the best of your ability and we will assist with the rest on the day of your appointment.

Appointment Day

Driving Directions and a map are included on the reverse side of this letter. If you are unsure of the direction, please call **(907) 561-1530 (Option 2)** for assistance.

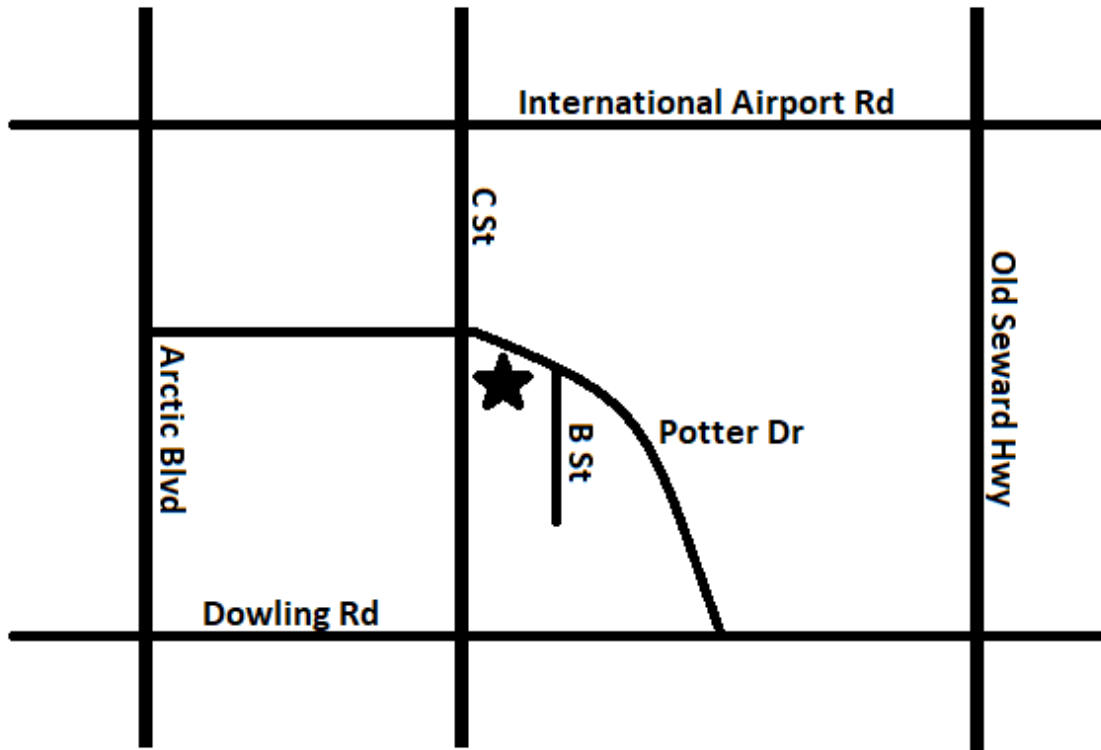
Your first appointment will be **1.5 to 2 hours** in length and your eyes will be dilated. If you are planning on having someone else provide you with transportation, please schedule accordingly.

Please arrive **10-15 minutes** before your scheduled appointment to allow enough time to process your insurance and ensure that your new patient documentation is complete. If you are late, we may need to delay or re-schedule your appointment. Please also make sure to bring a **photo ID and your insurance cards**.

If you will be unable to make the appointment and need to reschedule, please call **(907) 561-1530 (Option 2)**.

*Due to the Covid19 Pandemic we require that **only scheduled patients and medically necessary escorts** enter our building. We also require that everyone who enters our building wear a facemask. If you begin feeling symptoms before your appointment day, please call us at **(907) 561-1530**.*

Appointment Day Directions



★ - Alaska Retinal Consultants (5600 B St, Anchorage, Ak 99518)

If you are coming from **Wasilla**:

- As you enter Anchorage remain on Hwy 1 until you reach C St
- Turn left on C St, heading south
- Continue south until you cross over International Airport Rd
- Turn left on Potter Dr, heading east
- Turn right on B St, heading south
- Turn right into our parking lot

If you are coming from **Kenai**:

- As you enter Anchorage remain on Hwy 1 until you reach the exit for Dimond Blvd
- Turn left on Dimond, heading west
- Turn right on C St, heading north
- Turn right on Potter Dr, heading east
- Turn right on B St, heading south
- Turn right into our parking lot

If you are coming from **Ted Stevens International**:

- As you exit the airport campus you will be headed east on International Airport Rd
- Turn right on C St, heading south
- Turn left on Potter Dr, heading east
- Turn right on B St, heading south
- Turn right into our parking lot

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Demographics

Patient Information

Name: _____ Gender: _____

Date of Birth: ____ / ____ / ____ Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Emergency Phone: _____

Employer: _____ Emergency Contact: _____

Email: _____ Referring Physician: _____

Insurance Information

Primary: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Date of Birth: ____ / ____ / ____

Relationship to Patient: Self Spouse Parent

Secondary: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Date of Birth: ____ / ____ / ____

Relationship to Patient: Self Spouse Parent

Tertiary: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Date of Birth: ____ / ____ / ____

Relationship to Patient: Self Spouse Parent

Payment for services rendered by Alaska Retinal Consultants is your responsibility. We will be happy to submit claims to your insurance. If your insurance denies a claim for any reason you are responsible for payment to us.

I hereby authorize Alaska Retinal Consultants to release all information necessary to submit insurance claims. I assign all payments to Alaska Retinal Consultants.
Signature: _____ Date: ____ / ____ / ____

Medicare Lifetime Authorization

I request that payment under the medical insurance program be made either to me or to Alaska Retinal Consultants on any bills for services furnished to me during the effective period of this authorization and I authorize Alaska Retinal Consultants to release to the Social Security Administration or its intermediaries or carries any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: ____ / ____ / ____

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Authorization for Release of Information

Name: _____ **DOB:** _____

Alternate Names: _____ **Record #:** _____

Organization Releasing Information: _____

Organization(s) Receiving Information: _____

Description of Information to be Released: _____

I hereby authorize the use or disclosure of my healthcare and/or other information as described above. I understand that this authorization is voluntary. I understand that my records may contain sensitive information. I understand that I may revoke this authorization by signing the revocation form or by notifying Alaska Retinal Consultants (ARC) in writing. I understand that a revocation of this release will not have any effect on actions taken on this authorization before my revocation was received. I understand that ARC may condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

_____/_____/_____
(Signature of Client or Personal Representative) (Date)

(Printed Name of Personal Representative or Witness) (Description of Personal Representative's Authority)

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol/drug abuse patient.

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Medical History Questionnaire

Name: _____	Date Of Birth: _____
Pharmacy: _____	Location: _____
Reason for Today's Visit: _____ _____	

Current Symptoms (Check all that apply)			
<input type="checkbox"/> Flashes	<input type="checkbox"/> Floaters	<input type="checkbox"/> Distortion	<input type="checkbox"/> Blurred Vision
<input type="checkbox"/> Visual Field Defect	<input type="checkbox"/> Blank Spots	<input type="checkbox"/> Watery Eyes	<input type="checkbox"/> Pain/Irritation
<input type="checkbox"/> Light Sensitivity	<input type="checkbox"/> Discharge	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Foreign Body Sensation
<input type="checkbox"/> Other: _____			

Past Ocular History (Check All That Apply)			
<input type="checkbox"/> Overall Healthy	<input type="checkbox"/> Astigmatism	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Diabetic Retinopathy
<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Glasses/Contacts	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Optic Neuritis
<input type="checkbox"/> Ret. Detachment	<input type="checkbox"/> Retinal Tear	<input type="checkbox"/> Eye Trauma	<input type="checkbox"/> Prosthetic
<input type="checkbox"/> Other: _____			

Ocular Surgeries (Check All That Apply)			
<input type="checkbox"/> No Ocular Surgery	<input type="checkbox"/> Facial Cosmetic	<input type="checkbox"/> Cataract	<input type="checkbox"/> Corneal Transplant
<input type="checkbox"/> Foreign Body Removal	<input type="checkbox"/> Retinal Laser	<input type="checkbox"/> LASIK	<input type="checkbox"/> LASEK
<input type="checkbox"/> Radial Keratotomy	<input type="checkbox"/> Punctal Plugs	<input type="checkbox"/> Strabismus Surgery	<input type="checkbox"/> Glaucoma Surgery
<input type="checkbox"/> Vitrectomy	<input type="checkbox"/> Scleral Buckle	<input type="checkbox"/> Enucleation	<input type="checkbox"/> Other: _____

Family History (Check All That Apply)			
<input type="checkbox"/> Blindness	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> Mac. Degeneration	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Migraine	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Other: _____		

Review of Systems (Check All That Apply)			
Integumentary (Skin)			
<input type="checkbox"/> Skin Cancer	<input type="checkbox"/> Eczema	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Rosacea
<input type="checkbox"/> Other: _____			
Respiratory			
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> COPD
<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Other: _____	
Cardiovascular			
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Atherosclerosis	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Other: _____
Gastrointestinal			
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Liver Cancer	<input type="checkbox"/> Constipation	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Reflux/Heartburn	<input type="checkbox"/> Other: _____		
Genitourinary			
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Ovarian/Uterine CA	<input type="checkbox"/> Other: _____
Musculoskeletal			
<input type="checkbox"/> Rheum. Arthritis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fibro/Polymyalgia	<input type="checkbox"/> Sarcoidosis
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Gout	<input type="checkbox"/> Other: _____	
Neurological			
<input type="checkbox"/> Bell's Palsy	<input type="checkbox"/> Dementia	<input type="checkbox"/> Brain Tumor	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Migraines/Headaches	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Stroke (CVA)	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Other: _____
Endocrine			
<input type="checkbox"/> Type I Diabetes	<input type="checkbox"/> Type II Diabetes	<input type="checkbox"/> Diabetic Suspect	<input type="checkbox"/> Hypothyroidism
<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Graves' Disease	<input type="checkbox"/> Pituitary Tumor	<input type="checkbox"/> Other: _____
Hematologic/Lymphatic			
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Anemia	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Breast Cancer
<input type="checkbox"/> Hepatitis A/B/C	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Lupus	<input type="checkbox"/> Lyme Disease
<input type="checkbox"/> Lymphatic Cancer	<input type="checkbox"/> Herpes Simplex	<input type="checkbox"/> Herpes Zoster	<input type="checkbox"/> Histoplasmosis
<input type="checkbox"/> Shingles	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Toxoplasmosis	<input type="checkbox"/> Other: _____
Psychiatric			
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> PTSD
<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Other: _____		

Other Medical Diseases (Please List)

General Surgeries / Operations (Please List)

Medication Allergies	Reaction	Severity
		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

Any Sensitivity To
<input type="checkbox"/> Betadine <input type="checkbox"/> Iodine <input type="checkbox"/> Adhesive Tape <input type="checkbox"/> Erythomycin

Current Medication / Eye Drops / Vitamins / Minerals

Social History

Alcohol Use:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former How Often: _____ times per <input type="checkbox"/> Year <input type="checkbox"/> Month <input type="checkbox"/> Week <input type="checkbox"/> Day
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Tobacco Use:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former How Often: _____ times per <input type="checkbox"/> Year <input type="checkbox"/> Month <input type="checkbox"/> Week <input type="checkbox"/> Day
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Drug Use:	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Never
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Occupation:	_____ <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired
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Student:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Pregnant or Nursing:	<input type="checkbox"/> Yes <input type="checkbox"/> No Delivery Date: _____
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Living Situation:	<input type="checkbox"/> Alone <input type="checkbox"/> With Family <input type="checkbox"/> Care Facility
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Signature _____ Date: _____