

## ALASKA RETINAL CONSULTANTS

5600 B Street

ANCHORAGE, ALASKA 99518

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

Scott A Limstrom, 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

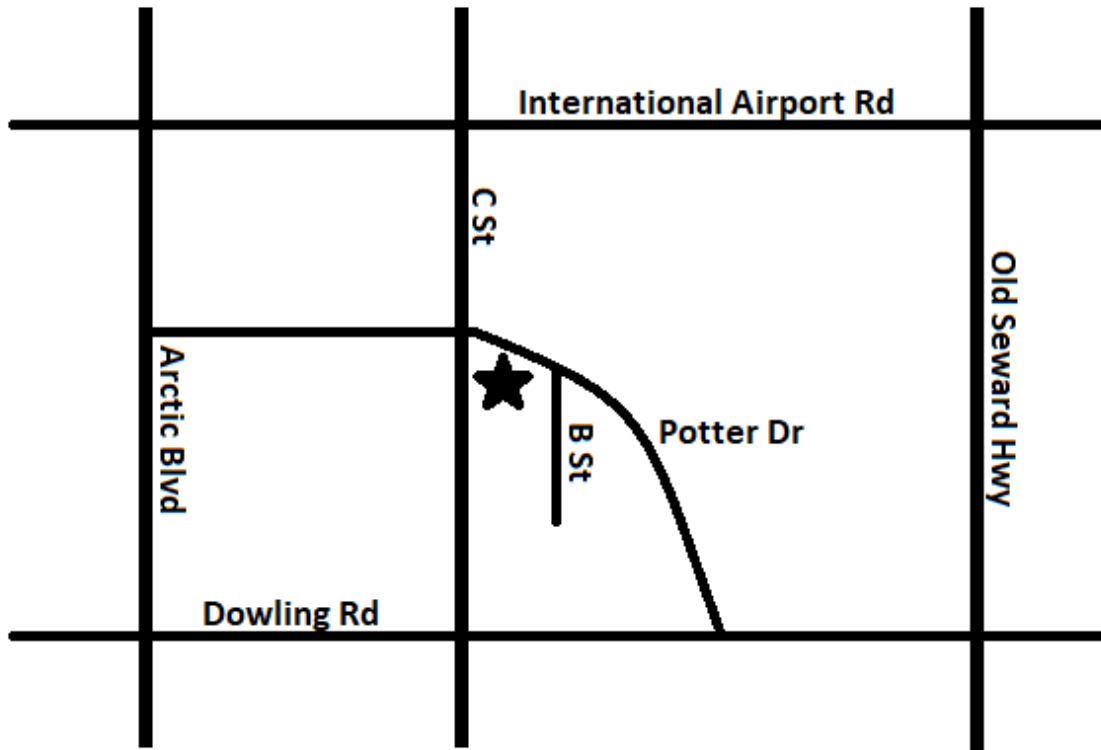
Driving Directions and a map are included on the reverse side of this letter. If you are unsure of the direction, please call **(907) 561-1530 (Option 2)** for assistance.

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)**.

## Appointment Day Directions



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### ★ - 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: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Pharmacist: \_\_\_\_\_

Pharmacist Address: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

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### 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

### Insurance/Medicare Lifetime Authorization

I/ We hereby state that the above information is true and correct to the best of my/ our knowledge. I/ We authorize the above-named practice to release any information acquired in the course of my treatment to my insurance company, Physicians, institutions or third-party payors, as required for certain claims filed. I/ We authorize direct payment to be made to the above-named practice for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility cannot be verified, I am responsible for all charges incurred. I/ We request that payment under the medical insurance program be made to Alaska Retinal Consultants on any bills for services furnished to I/ We. I/ We authorize Alaska Retinal Consultants to release to the Social Security Administration or its intermediaries or carriers any information needed for this 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:** Alaska Retinal Consultants

**Organization(s) Receiving Information:** Patient named above (Self), PCP \_\_\_\_\_,  
Referring \_\_\_\_\_, Other - \_\_\_\_\_

**Description of Information to be Released:** Requested Medical Information,

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. This ROI is good for 2 years from the date of signature.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**(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.

## Medical History Questionnaire

<b>Name:</b> _____	<b>Date Of Birth:</b> _____
<b>Pharmacy:</b> _____	<b>Location:</b> _____
<b>Reason for Today's Visit:</b> _____ _____	

### 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)

- Skin Cancer     Eczema     Psoriasis     Rosacea  
 Other: \_\_\_\_\_

### Respiratory

- Asthma     Bronchitis     Emphysema     COPD  
 Lung Cancer     Tuberculosis (TB)     Other: \_\_\_\_\_

### Cardiovascular

- High Blood Pressure     High Cholesterol     Atherosclerosis     Heart Disease  
 Arrhythmia     Pacemaker     Heart Attack     Other: \_\_\_\_\_

### Gastrointestinal

- Colon Cancer     Liver Cancer     Constipation     Ulcers  
 Reflux/Heartburn     Other: \_\_\_\_\_

### Genitourinary

- Kidney Disease     Prostate Cancer     Ovarian/Uterine CA     Other: \_\_\_\_\_

### Musculoskeletal

- Rheum. Arthritis     Arthritis     Fibro/Polymyalgia     Sarcoidosis  
 Osteoporosis     Gout     Other: \_\_\_\_\_

### Neurological

- Bell's Palsy     Dementia     Brain Tumor     Parkinson's Disease  
 Migraines/Headaches     Multiple Sclerosis     Meningitis     Seizures  
 Stroke (CVA)     Dizziness     Hearing Loss     Other: \_\_\_\_\_

### Endocrine

- Type I Diabetes     Type II Diabetes     Diabetic Suspect     Hypothyroidism  
 Hyperthyroidism     Graves' Disease     Pituitary Tumor     Other: \_\_\_\_\_

### Hematologic/Lymphatic

- AIDS/HIV     Anemia     Bleeding Disorder     Breast Cancer  
 Hepatitis A/B/C     Leukemia     Lupus     Lyme Disease  
 Lymphatic Cancer     Herpes Simplex     Herpes Zoster     Histoplasmosis  
 Shingles     Syphilis     Toxoplasmosis     Other: \_\_\_\_\_

### Psychiatric

- Anxiety     Depression     Bipolar Disorder     PTSD  
 Schizophrenia     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
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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: \_\_\_\_\_