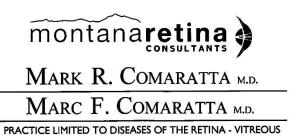


Patient Information

PATIENT NAME:	DATE OF BIRTH:			
ADDRESS:	CITY:			
STATE:ZIP CODE:	SOCIAL SECURITY NUMBER:			
PREFERRED PHONE: ()	SECONDARY PHONE: ()			
EMAIL:	MARITAL STATUS:			
EMPLOYER:	OCCUPATION:			
EMERGENCY CONTACT IN	FORMATION			
NAME:	RELATIONSHIP:			
PHONE NUMBER:()	ADDRESS:			
PRIMARY PHYSICIAN:				
NAME:	OFFICE:			
NAME:	OFFICE:			
PHARMACY:				
NAME:	CITY:			
NAME:	CITY:			
REFERRING PROVIDER				
NAME:	OFFICE:			
EVDI ANIATIONI COD DECEDDA	T .			

1940 WEST DICKERSON ST., SUITE 103 | BOZEMAN, MT 59718 PHONE: 406-284-2370 | FAX: 406-284-2372



PRIVACY AND FINANCIAL POLICIES

PATIENT NAME:		DATE OF BIRTH:				
PLEASE READ AND INITIAL THE FOLLOWING OFFICE POLICIES OF MONTANA RETINA CONSULTANTS						
R. Comaratta, MD or to the Centers of Med from Montana Retina I understand t	hat I am responsible for any bala	SENT to the release of med other Insurance companies nce not covered by Insurance	ical information during treatment ee. I agree to pay			
any reasonable collection costs and attorney fees if my account is placed in collection for non-						
payment. I understand that patients may be responsible for a \$50.00 fee that cannot be billed to insurance and must be paid on or before the next scheduled appointment should I not attend a scheduled appointment or do not provide 24-hour's notice to change a scheduled appointment. I understand that information related to my examinations at Montana Retina Consultants may be needed by outside medical offices for continuance of care, or to insurance companies to authorize payment of claims. I hereby authorize Montana Retina Consultants to release my information including the billing, condition, and treatment to parties covered under the Continuity of Care guidelines. AUTHORIZATION TO RELEASE INFORMATION I give my permission to release information regarding my medical condition and treatment to the following non-medical persons:						
ionowing non-medica	ii persons.					
Name:	Relationship:	Phone:				
	Relationship:					
Name:	Relationship:					
	Relationship:					
I acknowledge that I have been informed of Montana Retina Consultant's notice of Privacy and Financial Policies, and upon request, a copy shall be made available for my review at any time. I understand that this form shall stay in effect until changed or revoked by myself in writing.						
Signature of Patient/Gu	ardian:	Date:				

1940 WEST DICKERSON ST., SUITE 103 | BOZEMAN, MT 59718 PHONE: 406-284-2370 | FAX: 406-284-2372



PATIENT PORTAL

For easy access to your medical records online, please answer the following questions and return this form to Reception.

All information provided is confidential and this form will be returned to you before you leave our office. Information provided will be used for registration purposes only.

Please answer the following questions: What city were you born in? What state were you born in? What was the name of your best friend growing up?

PATIENT REVIEW OF SYSTEMS/MEDICAL HISTORY

PATIENT NAME:	PATIENT NAME: DATE OF BIRTH:			
MEDICAL HISTORY-PATIENT EYE (CIRCLE EYE) HOW LONG				
PLEASE CHECK ALL THAT APPLY:	_			
□RED EYES L R	\square Shadow/curtain/veil distortion L R	EYE INJURY L R		
□LOSS OF VISION: SUDDEN/GRAD		☐GLASSES/CONTACTS L R		
□ DRYNESS/WATERING L R	□HALOS L R	□EYE DISEASE L R		
□IRRITATION/EYE PAIN L R	\square LAZY EYE L R	□EYE SURGERY L R		
□FLOATERS L R	□GLAUCOMA L R	□CROSSED EYES L R		
DOUBLE VISION L R	□DISCHARGE L R	OTHER		
	MEDICAL HISTORY-PATIENT			
PLEASE CHECK ALL THAT APPLY:				
☐HIGH BLOOD PRESSURE CONTR				
	AIC: INSULIN DEPENDENT Y/N	CONTROLLED Y/N		
☐ HEART DISEASE	☐ HIGH CHOLESTEROL			
☐ HEART ATTACK	□PACEMAKER/DEFIBRILLATOR			
CHEST PAIN/ANGINA LAST EPISC	ODE: RELIEVED BY:			
□ HEART MURMUR	□ PNEUMOCOCCAL VACCINE Y/N WHEN:			
□ARRHYTHMIA	☐ INFLUENZA VACCINE Y/N WHEN:			
☐ HEART SURGERY	☐ HEART VALVE DISORDER LAST EPISODE:			
☐ HEART FAILURE				
□STROKE WHEN:	□ PERIPHERAL VASCULAR DISEASE			
□TIA/MINI STROKES				
☐BLEEDING DISORDERS	□seizures			
□PNEUMONIA	□ANEMIA			
□FEVER/WEIGHT LOSS	□ASTHMA/EMPHYSEMA			
☐ ON BIRTH CONTROL	□PREGNANT HOW FAR ALONG?:			
□HIV	□STD TYPE:			
□HEPATITIS TYPE:	☐TUBERCULOSIS/TB WHEN TREATED:			
□SICKLE CELL TRAIT	BLOOD TRANSFUSION WHEN:			
□KIDNEY DISEASE	KIDNEY FAILURE/DIALYSIS TYPE:			
□CANCER	□ARTHRITIS			
□BACK PROBLEMS	MIGRAINES			
□HEADACHES	DEPRESSION			
□ANXIETY	☐GASTRIC REFLUX			
□STOMACH PROBLEMS	□PSYCHIATRIC TREATMENT			
□BRONCHITIS	□ DIFFICULTY SWALLOWING			
MEDICAL HISTORY-FAMILY (INDICATE FAMILY MEMBER)				
□HEART DISEASE				
□GLAUCOMA	□DIABETES			
RETINAL DETACHMENTS	□LAZY EYE			
☐HIGH BLOOD PRESSURE				
□BLINDNESS				
FAMILY OR PERSONAL HISTORY C	F PROBLEMS WITH ANESTHESIA			

PATIENT REVIEW OF SYSTEMS/MEDICAL HISTORY

ALLERGIES					
□MEDICATIONS:					
□FOODS:		8			
□LATEX:					
□ADHESIVES (BANDAIDS, TAPE)	□NONE				
CURRENT MEDICATIONS-INCL	UDE OVER-THE-COUNTER AND EYE	DROPS/MEDICATIONS			
MEDICINE NAME (OR PROVIDE A COPY)	DOSE	HOW OFTEN DO YOU TAKE IT?			
	PREVIOUS SURGERIES				
PLEASE PROVIDE TYPE OF SURGERY AND YEAR					
	SOCIAL HISTORY				
WHAT IS YOUR TOBACCO USE HISTORY? USES TOBACCO: □CURRENTLY □NEVER □FORMERLY TOBACCO TYPE: □CIGARETTES □PIPE □CHEWING □CIGAR □SNUFF □SMOKELESS					
AMOUNT PER DAY: (PACKS, OUNCES,CIC PASSIVE SMOKE EXPOSURE: □YES □NO	GARS PIPES UNITS) NUMBER OF YE	ARS:			
WHAT IS YOUR ALCOHOL USE HISTORY? DRINKS ALCOHOL: □YES □NO □FORMERLY FREQUENCY: □OCCASSIONALLY/SOCIALLY □1 T DRINKS CAFFEINE: □YES □NO	O 2 DRINKS DAILY □3+ DRINKS DA	AILY			
RECREATIONAL DRUG USE: TYPE	_FREQUENCY				