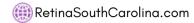
| Patient Name | | | | |
|----------------------------------------------------------------------------------------|----------------------------------|-----------------------------------------------------------------------------------------------------|--|--|
| | Last Name | First Name Middle Initial | | |
| Circle: Male / Female | Married / Widow / Single / Child | | | |
| Date of Birth | Age | Age Social Security Number | | |
| Preferred Language | | | | |
| EthnicityHispanic or Latino Not Hispanic or Latino Unknown Decline to Specify | | RaceAmerican Indian or Alaska NativeAsianBlack or African AmericanWhiteOther RaceDecline to Specify | | |
| Address | | | | |
| City/State/Zip | | | | |
| Home () | Work ()_ | Cell () | | |
| Email address | | | | |
| Preferred method of contact TEXT / | EMAIL / CALL | | | |
| Employer/School | | Occupation | | |
| Emergency Contact Name | | | | |
| Relationship to Patient | | | | |
| Home () | Work ()_ | Cell () | | |
| Check here if uninsured | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Check here if you are not under a Pi | rimary Care Phys | ician's Care | | |
| Primary Care Physician | | Phone Number | | |
| Eye Care Physician | | Phone Number | | |

| Patient Name | Date of Birth |
|------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| Last Eye Exam Pharmacy name and number_ | |
| List MEDICATIONS (RX and Over the Counter) | List all MAJOR ILLNESSES |
| | |
| Are you allergic to ANYTHING? YES NO If YES, list the medications | List any SURGERIES you have had |
| Do you CURRENTLY have any problems in the follow additional in | wing area? Please circle any that apply and provide nformation. |
| EYES – Poor Vision, Eye Pain, Tearing, Redness, Other | |
| GENERAL CONSTITUTION Fever, Heat Stroke, Weight L | oss, |
| Weight Gain, Fatigue, Other | |
| EARS, NOSE, THROAT Hearing Loss, Nasal Congestion, | |
| Earache, Cough, Dry mouth, Other CARDIOVASCULAR High Blood Pressure, Racing Pulse, | |
| Other | |
| RESPIRATORY Congestion, Wheezing, Shortness of Bre | ath. |
| Other | |
| GASTROINTESTINAL Nausea, Diarrhea, Constipation, | |
| Hernia, Ulcers, Other | |
| GENITAL/KIDNEY/BLADDER Painful Urination, Frequen | t |
| Urination, Impotence, Jaundice, Other | |
| FEMALES Pregnant /Nursing | |
| MUSCLES/BONES/JOINTS Joint Pain, Stiffness, Swelling | 5, |
| Cramps, Arthritis, Other | |
| SKIN Pimples, Warts, Growths, Rash, Other | |
| NEUROLOGICAL Numbness, Headaches, Seizures, Para | lysis, |
| Other | |
| PSYCHIATRIC Anxiety, Depression, Insomnia, Other | |
| ENDOCRINE Diabetes, Hypothyroid, Other | |
| BLOOD/LYMPH Bleeding, Cholesterolemia, Anemia, | |
| HIV/AIDS, Hepatitis, Other ALLERGIC/IMMUNOLOGIC Sneezing, Redness, Itching, | |
| Hives, Lupus, Other | |
| FAMILY HISTORY (Mother, Father, Sibling, Grandparent | Has any member of your family had these diseases |
| (Circle all that apply) BLINDNESS / CATARACT / GLAUG | |
| STROKE / CANCER / THYROID DISEASE / ARTHRITIS other | |
| | |
| SOCIAL HISTORY | |
| Does your Vision limit any activities of daily living (readi | ng, driving, sports, work, etc) YES NO |
| · · · · · · · · · · · · · · · · · · · | |
| Do you smoke YES NO If yes how much | How many years |

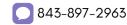


RETINA CONSULTANTS OF SOUTH CAROLINA





| 843-763-4466 |
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| 843-763-4466 |



| | 843-614-4285 |
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D. VIRGIL ALFARO, III, M.D. ERIC P. JABLON, M.D. JOHN B. KERRISON, M.D. MICHAEL A. JOHNSON, M.D. MONA L. CAMACCI, M.D. STEPHEN J. PHILIPS, M.D. SCOTT M. ANFINSON, M.D. GRIFFIN BRAME, M.D. MONICA F. RODRIGUEZ, M.D. (HONORARY)

FINANCIAL POLICY

Each patient is responsible for his or her own bill. I hereby authorize Retina Consultants of Charleston to release to my insurance company any information acquired during my examination or treatment.

Payment of all insurance co-payments and/or deductibles are due at the time medical services are rendered. Patients who have no insurance are required to pay 100% of services rendered at each visit. If this is impossible, you will need to make payment arrangements with our office prior to any medical evaluation for treatment. We accept cash, checks and major credit cards. Your

insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing you must provide all insurance policy information including any changes in coverage to this office. Your bill is your responsibility whether your insurance company pays or not. At times you may need to contact your insurance carrier regarding slow or nonpayment of your insurance claim. You are responsible for knowing what your insurance covers, your current copay amount and the

provider(s)/network(s)

covered under your health insurance plan. Any service provided but not covered by your insurance company will be your responsibility to pay. If your insurance company has not paid your full account within 60 days, you must pay the outstanding

balance without further delay.

A 35.00 fee will be charged on all returned checks.

I understand that this is a binding agreement between myself and Retina Consultants. I understand that I will be held responsible for any outstanding balances.

| X | |
|---------------------------------------------------------|------|
| Signature of patient (Parent/Legal Guardian if a minor) | Date |
| X | |
| Witness | Date |

Beaufort 1181 Ribaut Road Bluffton 8 Arley Way Downtown Charleston 701 East Bay Street Hilton Head 15A Lafayette Place Lake City 123 Epps Street



Mt. Pleasant 710 Johnnie Dodds Boulevard Myrtle Beach 8609 Montague Lane Ladson 9565 Highway 78 Orangeburg 125 Express Lane Walterboro 400 Constance Street West Ashley 3531 Mary Ader Avenue