Retina Associates of Missouri, P.C.
3600 Amron Court
Columbia, MO 65202
(573) 874-1616

By signing this form, I authorize the use and disclosure of my health information by, Retina Associates of Missouri, P.C., 3600 Amron Court, Columbia, MO 65202, any information including the diagnosis and records of any treatment or examination rendered to me.

Name or identification of person(s) authorized to receive the information:

_____

_____

_____

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses and disclosures have already been made based upon by original permission. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to Retina Associates of Missouri, P.C., 3600 Amron Court, Columbia, MO 65202.

I understand that it is possible that information used or disclosed with my permission may be redisclosed by recipient and no longer protected by the federal Privacy Standards.

Signature: _____

Printed Name:
Date of Birth:
Social Security NO:

Witness: _____

Retina Associates of Missouri

Jerry R. Blair, M.D., Ph.D. -- Mari Ann Keithahn, M.D.

Wayne Davis, D.O. -- Clint Kellogg, D.O.

REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid

Social Security Number	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Home Phone: ( )	Cell Phone: ( )

P.O. box:	City:	State:	ZIP Code:

Email Address:

Occupation:	Employer:	Employer phone no.:

Ethnicity : Hispanic or Latino / Not Hispanic or Latino / Unknown / Decline to Specify

Race: White / Black or African American / American Indian or Alaska Native /
Native Hawaiian or Other Pacific Islander / Asian / Other Race / Declined to Specify

Referring Physician:	Family Physician:

RESPONSIBLE FOR ACCOUNT

Person responsible for account (if other than Patient)	Birth date: / /	Address (if different):	Home phone no.: ( )

Relationship to Patient:

Employer:	Employer address:	Employer phone no.:

INSURANCE INFORMATION

(Please give your insurance card and photo ID to the Receptionist)

Please indicate primary Insurance Carrier:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

I authorize release of any information concerning my(or my child's) health care and treatment provided for the purpose of evaluating and administering claims for insurance benefits and to referring physicians. I also hereby authorize payment of insurance benefits directly to the physician and acknowledge that I am financially responsible for any unpaid balance. I understand that should my account become delinquent and collective action become necessary I may be responsible for additional fees associated with collective action. I further acknowledge that I have received a copy of the Notice of Privacy Practices.

Patient/Guardian signature	*Date*

MEDICARE PATIENTS PLEASE COMPLETE THE MEDICARE AUTHORIZATION ON THE BACK

Retina Associates of Missouri

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Wayne Davis, D.O. -- Clint Kellogg, D.O.

PATIENT'S MEDICARE, MEDIGAP AND SUPPLEMENTAL AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to RETINA ASSOCIATES OF MISSOURI, P.C. for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

AUTHORIZATION: I hereby authorize my insurance benefits to be paid directly to RETINA ASSOCIATES OF MISSOURI, P.C. and acknowledge that I am financially responsible for any unpaid balance.

AUTHORIZATION: I authorize RETINA ASSOCIATES OF MISSOURI, P.C. to release any medical information to insurance carriers and to referring physicians concerning my health care and treatments.

Print Patient Name	Medicare Number
Patient/Guardian Signature	*Date*

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Wayne E. Davis, D.O.
Clint W. Kellogg, D.O.

Vitreoretinal Diseases and Surgery

Medical History Questionnaire

Name:_____ Today's Date_____

Date of Birth_____ Reason for todays visit:_____

Eye History: (please circle all that apply)

Vision Loss Blurred Vision Loss of Side Vision Double Vision
Floaters Flashes Distortion Foreign Body Sensation
Redness Pain/Soreness Eye Injury Glare/Light Sensitivity
Other:_____

List all previous eye surgeries, lasers, or injuries: _____

_____

Do you currently have any problems in the following areas? **Please circle all that apply**:

General/Constitutional:
fever, weight loss, fatigue, etc.

Head, Ear, Nose, Throat:
runny nose, dry mouth, hearing loss, etc.

Cardiovascular:
high blood pressure, irregular heart beat, chest pain, shortness of breath, etc.

Respiratory:
shortness of breath, wheezing or asthma attacks, cough, coughing up blood, etc.

Gastrointestinal:
Nausea, vomiting, acid reflux, stomach ulcers, gastrointestinal ulcers, bloody stools, jaundice or yellow skin, etc.

Genitals/Kidney/Bladder:
Pain/burning on urination, frequent urination, blood in urine, etc.

Muscles/Bones/Joints:
joint pain, stiffness, swelling, arthritis, etc.

Skin:
rash, skin cancer, etc.

Neurological:
numbness, weakness, headaches, seizures or convulsions, stroke, etc.

Psychiatric:
anxiety, depression, change in sleep pattern, etc.

Endocrine:
diabetes, hypothyroid, etc.

Blood/Lymph:
high cholesterol, anemia, bleeding problems, etc.

Allergic/Immunologic:
sneezing, itching, hives, lupus, etc.

Other:_____

_____

OVER→

3600 Amron Court Columbia, Missouri 65202-1918 Telephone 573/874-1616 Fax: 573/875-0300

Preferred Pharmacy: _____

Address: _____ Phone: _____

List any **medications** you currently take and dosage: _____

_____

Do you have any **allergies** to any medications? YES NO
If YES, list the medications: _____

List all **major illnesses/injuries** (diabetes, high blood pressure, heart attack, cancer, eye trauma, etc.)

_____

_____

List any **surgeries** you have had: _____

_____

Family History: (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases?
Blindness, Glaucoma, Retinal Detachment, Macular Degeneration
Diabetes, High Blood Pressure, Heart Disease, Stroke, Cancer
other heritable disease: _____

Social History:

Current Occupation: _____
Does your vision limit any activities of daily living (driving, reading, work, sports, etc) YES NO
Have you ever had a blood transfusion? YES NO
Do you drink alcohol? YES NO If YES, how much _____
Do you smoke? YES NO If YES, how much _____ years? _____

List doctors you are currently seeing: _____

_____

Patient Signature: _____ Date: _____

For Office Use Only:
Physician Signature: Date: