

**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:

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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 my 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.**  
**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)<br>Single / Mar / Div / Sep / Wid |                                                                         |
| Social Security Number                                                                                                                                                                          |       |           | Birth date:<br>/ /   |                                                               | Age:      Sex:<br><input type="checkbox"/> M <input type="checkbox"/> F |
| Street address:                                                                                                                                                                                 |       |           | Home Phone:<br>(   ) |                                                               | Cell Phone:<br>(   )                                                    |
| 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   /<br>Native Hawaiian or Other Pacific Islander   /   Asian   /   Other Race   /   Declined to Specify |       |           |                      |                                                               |                                                                         |
| Referring Physician:                                                                                                                                                                            |       |           | Family Physician:    |                                                               |                                                                         |

**RESPONSIBLE FOR ACCOUNT**

|                                                           |                    |                         |                          |
|-----------------------------------------------------------|--------------------|-------------------------|--------------------------|
| Person responsible for account<br>(if other than Patient) | Birth date:<br>/ / | Address (if different): | Home phone no.:<br>(   ) |
| 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:<br>/ / | Group no.: | Policy no.: |
| Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other |                        |                    |            |             |
| Name of secondary insurance (if applicable):                                                                                                                      |                        | Subscriber's name: | Group no.: | Policy no.: |
| Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other |                        |                    |            |             |

**IN CASE OF EMERGENCY**

|                             |                          |                          |                          |
|-----------------------------|--------------------------|--------------------------|--------------------------|
| Name of friend or relative: | Relationship to patient: | Home phone no.:<br>(   ) | Work phone no.:<br>(   ) |
|-----------------------------|--------------------------|--------------------------|--------------------------|

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**  
**Jerry R. Blair, M.D., Ph.D.**  
**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 |
| <i>Patient/Guardian Signature</i> | <i>Date</i>     |



# Retina Associates of Missouri, P.C.

Jerry R. Blair, M.D., Ph.D.  
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 today's 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.

Other: \_\_\_\_\_

#### 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.

OVER→

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: \_\_\_\_\_