RETINA CARE SPECIALISTS

Patient name: _____ DOB: _____

email: _____

CIRCLE ONE: I **have / have not** been vaccinated for **influenza** this season: year _____

CIRCLE ONE: I **have / have not** been previously vaccinated for **pneumonia**.

CIRCLE ONE: SMOKING STATUS - never / current / former (total years ____ packs per day ____)

___ I hereby authorize the above-mentioned medical practice to contact me by telephone and if I am not available, they may leave a message on my answering machine.

___ **DO NOT** leave a message on my answering machine other than the name of the caller and telephone number.

EMERGENCY CONTACTS/OTHER CONTACT INFORMATION

The following people should be contacted in the event of a medical emergency and are authorized to discuss my medical condition/billing info with the healthcare professionals in this practice.

Name: _____

Relationship: _____

Contact number: _____

Name: _____

Relationship: _____

Contact number: _____

RELEASE OF INFORMATION

I hereby authorize any doctor, hospital or medical facility to release records to Retina Care Specialists - Drs. Mark Michels, Adrian Laviña, Paul Gallogly and Philip Laird. I authorize Retina Care Specialists to import/access a current list of my prescribed medications from the Surescripts national database into my electronic medical record .

Patient signature: _____

Witness: _____ Date: _____