Midwest Retina Associates, Inc.

Robert Corman Fletcher, M.D.

Diseases and Surgery of the Retina and Vitreous

Date_____ Date of Birth_____

Patient's Name_____

Patient's Address: Street_____City_____State_____Zip Code_____

Telephone: Home _____

Work _____ SS# _____ - _____ - _____

Occupation:

Employer:

Emergency contact name and phone:

Referring Physician:

Responsible Party:

Medicare No.:

Insurance Company:

Policy No.: Group No.:

Brief description of your eye problem and when it began:

PREVIOUS EYE HISTORY AND SURGERY:

Glaucoma:

Family History of eye disease or blindness:

GENERAL MEDICAL HISTORY:

Diabetes _____ yrs.

Hypertension _____ yrs.

Heart Disease _____ yrs. What Kind? _____

Other

(Over)

ANY PREVIOUS OPERATIONS OF ANY KIND:

ALLERGIES:

MEDICATIONS CURRENTLY TAKEN:

AUTHORIZATION AND ACKNOWLEDGEMENT

I hereby authorize Midwest Retina Associates, Inc. to release information about my care to the following parties: my physician, my insurance Company and the Department of Motor Vehicles.

In connection with the medical services which I am receiving from Midwest Retina Associates, Inc. I consent that photographs may be taken of my eyes or face under the following conditions: 1) The photographs may be taken only with the consent of Midwest Retina Associates. Inc. and under such conditions and at such times as approved by Midwest Retina Associates, Inc. 2) The photographs shall be taken by a competent photographer 3) These photographs shall be used for medical records only, unless, In the judgement of Midwest Retina Associates, Inc., medical research, education or science will benefit from their use. In that event I agree that they may be used for such purposes, provided that my identity is not revealed by the photographs or by descriptive text accompanying them.

I understand that I am responsible for all fees and charges incurred during the course of my treatment, and I agree to pay all costs and expenses incurred, including reasonable attorney fees, in the event this account is placed in the hands of an attorney for collection.

_____ _____

Patient Signature (Or Parent, if a Minor) Witness

AUTHORIZATION TO RELEASE INFORMATION & PAYMENT:

I AUTHORIZE MIDWEST RETINA TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF TREATMENT OR EXAM AND DIRECT PAYMENT DIRECTLY TO MIDWEST RETINA ASSOCIATES.

SIGNED: _____ DATE:_____