ALASKA RETINAL CONSULTANTS
5600 B Street
ANCHORAGE, ALASKA 99518
907-561-1530 FAX: 907-561-2611
Scott A Limstrom, MD Matthew G Guess, MD Chad Bouchard, DO

Welcome to Alaska Retinal Consultants

You are receiving this letter because you have been referred to our clinic for an evaluation of your retina. We welcome the privilege of participating in your care and will do everything possible to make your experience with us a positive one.

Pre-Appointment Preparations

In this packet you will find **Demographics**, **Release of Information**, and **Medical History Questionnaire** forms. We ask that you complete and return these forms to **Alaska Retinal Consultants** prior to your appointment. Completing your new patient packet beforehand will help save you time on the day of your appointment.
If you are unable to return the packet before your appointment, please have it with you on appointment day.

You can return your completed packet by one of these means:

- **Email**: Scheduling@alaskaretina.com
- **Fax**: (907) 561-2611 (Attn: Admin)
- **Mail**: 5600 B Street, Anchorage, AK 99518 (Attn: Admin)

If you have any difficulty completing these forms, please fill them out to the best of your ability and we will assist with the rest on the day of your appointment.

Appointment Day

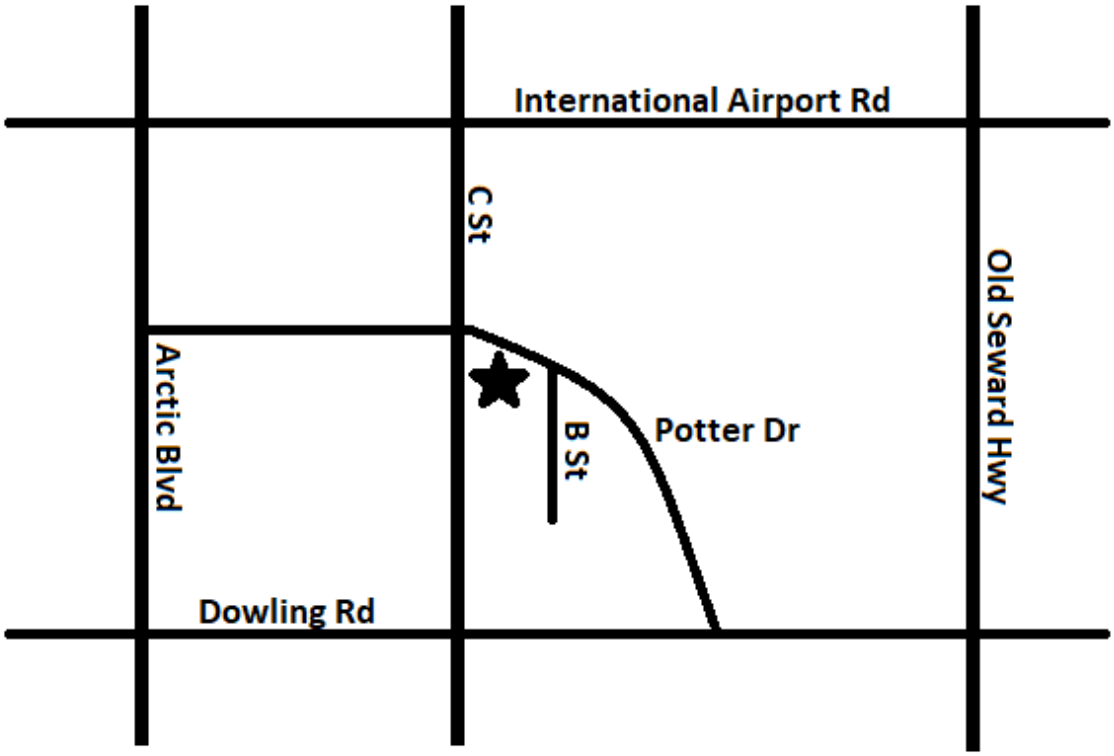
Driving Directions and a map are included on the reverse side of this letter. If you are unsure of the direction, please call **(907) 561-1530 (Option 2)** for assistance.

Your first appointment will be **1.5 to 2 hours** in length and your eyes will be dilated. If you are planning on having someone else provide you with transportation, please schedule accordingly.

Please arrive **10-15 minutes** before your scheduled appointment to allow enough time to process your insurance and ensure that your new patient documentation is complete. If you are late, we may need to delay or re-schedule your appointment. Please also make sure to bring a **photo ID and your insurance cards**.

If you will be unable to make the appointment and need to reschedule, please call **(907) 561-1530 (Option 2).**

Appointment Day Directions



★ - Alaska Retinal Consultants (5600 B St, Anchorage, AK 99518)

If you are coming from **Wasilla**:

As you enter Anchorage remain on Hwy 1 until you reach C St
Turn left on C St, heading south
Continue south until you cross over International Airport Rd
Turn left on Potter Dr, heading east
Turn right on B St, heading south
Turn right into our parking lot

If you are coming from **Kenai**:

As you enter Anchorage remain on Hwy 1 until you reach the exit for Dimond Blvd
Turn left on Dimond, heading west
Turn right on C St, heading north
Turn right on Potter Dr, heading east
Turn right on B St, heading south
Turn right into our parking lot

If you are coming from **Ted Stevens International**:

As you exit the airport campus you will be headed east on International Airport Rd
Turn right on C St, heading south
Turn left on Potter Dr, heading east
Turn right on B St, heading south
Turn right into our parking lot

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Demographics

Patient Information

Name: _____ **Gender:** _____

Date of Birth: ____ / ____ / ____ **Social Security Number:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Emergency Phone:** _____

Employer: _____ **Emergency Contact:** _____

Email: _____ **Referring Physician:** _____

Primary Care Physician: _____

Insurance Information

Primary: _____

Policy Number: _____ **Group Number:** _____

Policy Holder: _____ **Date of Birth:** ____ / ____ / ____

Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Parent**

Secondary: _____

Policy Number: _____ **Group Number:** _____

Policy Holder: _____ **Date of Birth:** ____ / ____ / ____

Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Parent**

Tertiary: _____

Policy Number: _____ **Group Number:** _____

Policy Holder: _____ **Date of Birth:** ____ / ____ / ____

Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Parent**

Payment for services rendered by Alaska Retinal Consultants is your responsibility. We will be happy to submit claims to your insurance. If your insurance denies a claim for any reason you are responsible for payment to us.

I hereby authorize Alaska Retinal Consultants to release all information necessary to submit insurance claims. I assign all payments to Alaska Retinal Consultants.

Signature: _____ **Date:** ____ / ____ / ____

Medicare Lifetime Authorization

I request that payment under the medical insurance program be made either to me or to Alaska Retinal Consultants on any bills for services furnished to me during the effective period of this authorization and I authorize Alaska Retinal Consultants to release to the Social Security Administration or its intermediaries or carries any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

Signature: _____ **Date:** ____ / ____ / ____

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Authorization for Release of Information

Name: _____ **DOB:** _____

Alternate Names: _____ **Record #:** _____

Organization Releasing Information: Alaska Retinal Consultants

Organization(s) Receiving Information: Patient named above (Self),

Description of Information to be Released: _____

I hereby authorize the use or disclosure of my healthcare and/or other information as described above. I understand that this authorization is voluntary. I understand that my records may contain sensitive information. I understand that I may revoke this authorization by signing the revocation form or by notifying Alaska Retinal Consultants (ARC) in writing. I understand that a revocation of this release will not have any effect on actions taken on this authorization before my revocation was received. I understand that ARC may condition my treatment, payment, enrollment in a health plan (if applicable) or eligibilitly for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

_____ ____/____/____

(Signature of Client or Personal Representative) **(Date)**

_____ _____

(Printed Name of Personal Representative or Witness) **(Description of Personal Representative's Authority)**

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol/drug abuse patient.

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Medical History Questionnaire

Name: _____ **Date Of Birth:** _____

Pharmacy: _____ **Location:** _____

Reason for Today's Visit: _____

Current Symptoms (*Check all that apply*)

☐ Flashes	☐ Floaters	☐ Distortion	☐ Blurred Vision
☐ Visual Field Defect	☐ Blank Spots	☐ Watery Eyes	☐ Pain/Irritation
☐ Light Sensitivity	☐ Discharge	☐ Double Vision	☐ Foreign Body Sensation

☐ Other: _____

Past Ocular History (*Check All That Apply*)

☐ Overall Healthy	☐ Astigmatism	☐ Cataracts	☐ Diabetic Retinopathy
☐ Dry Eyes	☐ Glasses/Contacts	☐ Glaucoma	☐ Optic Neuritis
☐ Ret. Detachment	☐ Retinal Tear	☐ Eye Trauma	☐ Prosthetic

☐ Other: _____

Ocular Surgeries (*Check All That Apply*)

☐ No Ocular Surgery	☐ Facial Cosmetic	☐ Cataract	☐ Corneal Transplant
☐ Foreign Body Removal	☐ Retinal Laser	☐ LASIK	☐ LASEK
☐ Radial Keratotomy	☐ Punctal Plugs	☐ Strabismus Surgery	☐ Glaucoma Surgery
☐ Vitrectomy	☐ Scleral Buckle	☐ Enucleation	☐ Other: _____

Family History (*Check All That Apply*)

☐ Blindness	☐ Cancer	☐ Cataracts	☐ Diabetes
☐ Glaucoma	☐ Retinal Detachment	☐ Mac. Degeneration	☐ Kidney Disease
☐ High Blood Pressure	☐ Migraine	☐ Heart Disease	☐ Stroke
☐ Thyroid Disease	☐ Other: _____		

Review of Systems (*Check All That Apply*)

Integumentary (Skin)

☐ Skin Cancer ☐ Eczema ☐ Psoriasis ☐ Rosacea

☐ Other: _____

Respiratory

☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ COPD

☐ Lung Cancer ☐ Tuberculosis (TB) ☐ Other: _____

Cardiovascular

☐ High Blood Pressure ☐ High Cholesterol ☐ Atherosclerosis ☐ Heart Disease

☐ Arrhythmia ☐ Pacemaker ☐ Heart Attack ☐ Other: _____

Gastrointestinal

☐ Colon Cancer ☐ Liver Cancer ☐ Constipation ☐ Ulcers

☐ Reflux/Heartburn ☐ Other: _____

Genitourinary

☐ Kidney Disease ☐ Prostate Cancer ☐ Ovarian/Uterine CA ☐ Other: _____

Musculoskeletal

☐ Rheum. Arthritis ☐ Arthritis ☐ Fibro/Polymyalgia ☐ Sarcoidosis

☐ Osteoporosis ☐ Gout ☐ Other: _____

Neurological

☐ Bell's Palsy ☐ Dementia ☐ Brain Tumor ☐ Parkinson's Disease

☐ Migraines/Headaches ☐ Multiple Sclerosis ☐ Meningitis ☐ Seizures

☐ Stroke (CVA) ☐ Dizziness ☐ Hearing Loss ☐ Other: _____

Endocrine

☐ Type I Diabetes ☐ Type II Diabetes ☐ Diabetic Suspect ☐ Hypothyroidism

☐ Hyperthyroidism ☐ Graves' Disease ☐ Pituitary Tumor ☐ Other: _____

Hematologic/Lymphatic

☐ AIDS/HIV ☐ Anemia ☐ Bleeding Disorder ☐ Breast Cancer

☐ Hepatitis A/B/C ☐ Leukemia ☐ Lupus ☐ Lyme Disease

☐ Lymphatic Cancer ☐ Herpes Simplex ☐ Herpes Zoster ☐ Histoplasmosis

☐ Shingles ☐ Syphilis ☐ Toxoplasmosis ☐ Other: _____

Psychiatric

☐ Anxiety ☐ Depression ☐ Bipolar Disorder ☐ PTSD

☐ Schizophrenia ☐ Other: _____

Other Medical Diseases (Please List)

_____

_____

_____

General Surgeries / Operations (*Please List*)

_____ _____

_____ _____

_____ _____

Medication Allergies	Reaction	Severity
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe

Any Sensitivity To

☐ Betadine ☐ Iodine ☐ Adhesive Tape ☐ Erythomycin

Current Medication / Eye Drops / Vitamins / Minerals

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Social History

Alcohol Use:	☐ Yes ☐ No ☐ Former How Often: _____ times per ☐ Year ☐ Month ☐ Week ☐ Day
Tobacco Use:	☐ Yes ☐ No ☐ Former How Often: _____ times per ☐ Year ☐ Month ☐ Week ☐ Day
Drug Use:	☐ Current ☐ Past ☐ Never
Occupation:	_____ ☐ Full Time ☐ Part Time ☐ Retired
Student:	☐ Yes ☐ No
Pregnant or Nursing:	☐ Yes ☐ No Delivery Date: _____
Living Situation:	☐ Alone ☐ With Family ☐ Care Facility

Signature _____ **Date:** _____