RETINA CONSULTANTS
OF PUERTO RICO

WILLIAM TOWNSEND PICO, MD
JESSICA CEDEÑO RICHIEZ, MD
FERDINAND RODRIGUEZ AGRAMONTE

Name: Fecha cita:

Chart:

Date:

PATIENT REGISTRATION FORM

First Name	MI	Last Name	Sex

Home Address	City	State Zip Code

Home Phone	Work Phone	Cell Phone	Preferred method of contact

Date of Birth	Age	Social Security Number	Marital Status ☐S ☐M ☐D ☐W	E-mail Address

Preferred Pharmacy, Name, Address, and Phone

I agree that The Retina Consultants of Puerto Rico, PC may request and use my prescription medication history from other heathcare providers or third pharmacy benefit payers for treatment purposes.

Signature: _____ Date: _____

Emergency Contact	Relationship	Phone number

Referring Physician	Phone number

Primary Care Physician	Phone number

INSURANCE INFORMATION

Primary Insurance:

Carrier: _____ Address: _____ Phone: _____

ID#: _____ Group #: _____ Effective Date: _____

Policyholder: _____ Policyholder SSN: _____ DOB: _____

Secondary Insurance:

Carrier: _____ Address: _____ Phone: _____

ID#: _____ Group #: _____ Effective Date: _____

Policyholder: _____ Policyholder SSN: _____ DOB: _____

Please answer the following question to the best of your knowledge
Do any blood relatives, LIVING or DECEASED, have any of the following conditions?

Condition	Relation/Status	Condition	Relation/Status
Diabetes		Cancer	
High Blood Pressure		Hereditary Eye Disease	
Heart Disease		Diabetic Retinopathy	
Tuberculosis		Glaucoma	
Kidney Disease		Macular Degeneration	
Migraine Headaches		Retinal Detachment	
Stroke		Other:	

Patient Name: _____ Appointment Date: _____

MEDICATION	MG	TIMES	SURGERIES	DATE

Allergies: Food _____ Medication _____

MEDICAL HISTORY

OCULAR No Past Ocular History: ☐

Have you ever had?	Y	N	Date of Onset
Retinal Detachment			
Flashes			
Floaters			
Loss of Vision			
Diabetic Retinopathy			
Macular Degeneration			
Hereditary Eye Disease			
Glaucoma			
Retinal Vein Occlusion			
Ocular Migraines			
Amblyopia (Lazy eye)			
Glaucoma			
Cataracts			
Extreme Dry Eyes			
Other:			

SYSTEMIC: No Past Medical History: ☐

Have you ever had?	Y	N	Date of Onset
Diabetes: Type 1 or Type II			
High Blood Pressure			
Heart Problems			
Asthma/Emphysema/TB/COPD			
Kidney Problems? Dialysis ☐			
Cancer			
Migraines			
Weaked Immune System			
High Cholesterol			
Other Illnesses: No ☐			