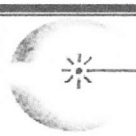

Connecticut Retina Consultants, L.L.C.

www.ctretina.com

Matthew Dombrow, M.D.
Philip M. Falcone, M.D.
Wayne I. Larrison, M.D.
Nancy Miller-Rivero, M.D.
James M. Weisz, M.D.

Welcome to Connecticut Retina Consultants

Established in 1990, Connecticut Retina Consultants offers comprehensive care of medical and surgical retinal diseases, including macular degeneration, diabetic retinopathy, retinal detachment, retinal venous occlusive disease and uveitis. Our doctors are all expertly trained to treat these complex retinal problems. The first group in Connecticut to perform complex retinal operations including macular hole surgery and pneumatic retinopexy, our doctors continue to be the most accomplished vitreo-retinal surgeons, at the leading edge of retinal and uveitis care. Convenient in-office laser, ultrasound, fluorescein angiography, and ocular coherence tomography (OCT) services allow rapid diagnosis and treatment. Many surgical procedures can be performed in the office as well. For more complicated procedures, outpatient, local anesthesia is used. Available for consultation and second opinions, we have convenient locations in New Haven, Bridgeport, Hamden, Madison, and Norwalk.

On the day of your appointment, please bring the following with you:

- Your photo ID
- *Current health insurance card(s)*
- A completed Patient Registration form (enclosed)
- A completed Medical History form (enclosed)
- If you wear eyeglasses please bring them to your appointment
- A list of any medications, including dosage

Your eyes will be fully dilated to ensure a thorough retinal exam, and may be dilated for 21-36 hours afterward. For safety, we recommend that someone drive you home from each visit.

Thank you again for choosing Connecticut Retina Consultants! We look forward to serving you!

Bridgeport
4920 Main St, Suite 309, Bridgeport CT, 06606
P: 203-365-6565
F: 203-365-6567

Hamden
2440 Whitney Avenue, Suite 103, Hamden CT, 06518
P: 203-248-8080
F: 203-535-0860

Madison
6 Woodland Road, Suite 2, Madison CT, 06443
P: 203-245-4544
F: 203-779-5337

New Haven
46 Prince Street, Suite 203, New Haven CT, 06519
P: 203-787-6161
F: 203-776-0300

Norwalk
111 East Avenue, Suite 335, Norwalk CT, 06851
P: 203-365-6565
F: 203-365-656

Connecticut Retina Consultants, L.L.C.

MRN #_____

MEDICAL HISTORY FORM

Name: _____ **Date of Birth:** _____ **Age:** _____ **Date:**_____

Height:____ Weight: _____ Sex: Male / Female **Primary Care Physician:** _____

CONDITIONS:	**Circle any and all conditions that apply to you or check none.**	**NONE**
GENERAL:	fever, heat stroke, weight loss, weight gain, fatigue, insomnia, headaches	
EARS, NOSE, THROAT:	hard of hearing, ear ache, cough, dry mouth, sinus/allergy, hoarseness, vertigo	
CARDIOVASCULAR:	high B/P, heart attack, chest pain, congestive heart failure, racing pulse, high cholesterol, irregular heartbeat, palpitations, pace maker	
RESPIRATORY:	congestion, wheezing, short of breath, asthma, COPD, emphysema, TB exposure	
GASTROINTESTINAL:	stomach upset, diarrhea, constipation, hernia, ulcers, nausea, GERD,	
GENITOURINARY:	painful/ frequent urination, impotence, yellow jaundice, kidney stones, blood in urine	
FEMALES:	Are you pregnant? Are you nursing?	
MUSCULOSKELETAL:	joint pain, stiffness, swelling, cramps, fibromyalgia, rheumatoid arthritis, lupus, other type arthritis, osteoporosis	
DERMATOLOGIC:	pimples, acne, warts, growths, rash, rosacea, melanoma	
NEUROLOGICAL:	numbness, headache, seizures, paralysis, stroke, dementia, memory loss, Alzheimer's, Parkinson's	
PSYCHIATRIC:	anxiety, depression,	
ENDOCRINE:	diabetes, hypothyroid, hyperthyroid, hormone, increased thirst , Graves Disease, Thyroid Eye Disease	
HEMATOLOGY:	bleeding, anemia, blood clots, problems related to blood transfusions,	
ALLERGIC/IMMUNOLOGIC:	sinus, sneezing, swelling, redness, itching, hives, lupus, HIV, Herpes Simplex Virus, Sjogren's Syndrome, rheumatoid arthritis,	
CANCER:	breast, prostate, lung, skin, colon , other _____	
EYES:	cataract, glaucoma, detached retina, blindness, lazy eye, eye injury/trauma, corneal problems, macular degeneration	

List all Eye Surgeries & Laser Eye Surgeries:

_____

_____

List all OTHER surgeries you have had:

_____

_____

FAMILY HISTORY: Has any member of your immediate family (blood relatives) have/had these diseases?

Disease/Condition	**Family Member**	**Disease/Condition**	**Family Member**
Lazy Eye yes no	Mother Father Sibling Grandparent	Heart Disease yes no	Mother Father Sibling Grandparent
Macular Degeneration yes no	Mother Father Sibling Grandparent	Hypertension yes no	Mother Father Sibling Grandparent
Blindness yes no	Mother Father Sibling Grandparent	Stroke yes no	Mother Father Sibling Grandparent
Retinal Disorders yes no	Mother Father Sibling Grandparent	Thyroid Disease yes no	Mother Father Sibling Grandparent
Cataracts yes no	Mother Father Sibling Grandparent	Arthritis yes no	Mother Father Sibling Grandparent
Glaucoma yes no	Mother Father Sibling Grandparent	Cancer yes no	Mother Father Sibling Grandparent
Diabetes yes no	Mother Father Sibling Grandparent	Type of Cancer: _____	Mother Father Sibling Grandparent

Physician/Technician Signature: _____ **Date:** _____

All information you provide is confidential and will not be released to anyone without your consent

Connecticut Retina Consultants, L.L.C.

MRN #__________

MEDICAL HISTORY FORM

SOCIAL HISTORY:

(**Circle:)** Student Homemaker Employed Retired **(Circle:)** Single Married Separated Divorced Widowed

Do you use Tobacco? Yes / No Cigarettes / Smokeless _____ # Packs/Times a Day ______# of Years

Do you use Alcohol? Yes / No Rarely Daily Weekly 1-2 drinks 2-4 drinks Other ___________

Substance Abuse? Yes / No Rarely Daily Weekly ___________________________________

LIST ANY DRUG ALLERGIES: ____

____

List all Prescriptions and Over the Counter medications you are taking: (Including Eye Drops)

If you have a list, please give to receptionist to copy in lieu of filling out form:

Medication Name	Dosage	Taken how often ? PRN= when needed	Route	Reason for taking	Currently Taking Yes	No
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection			

REVIEWED:

Staff	*Date*

Physician/Technician Signature: ______________________________ **Date:** ______________

All information you provide is confidential and will not be released to anyone without your consent

Connecticut Retina Consultants, L.L.C.

MRN#_____

PATIENT REGISTRATION

PATIENT INFORMATION

First | MI | Last | Suffix | DOB

Address | City | State | Zip Code

( ) Home Phone | ( ) Cell Phone | ( ) Other

Marital Status: □ Single □ Married □Widowed □Divorced

Gender: □ Male □ Female

Social Security # _____

Emergency Contact | Relationship | ( ) Phone

Employer | ( ) Phone/Ext | Address

PHYSICIAN INFORMATION:

Primary Care Physician | Street Address | City | State | ( ) Phone #

Referring Physician | Street Address | City | State | ( ) Phone #

INSURANCE INFORMATION: (Please give insurance cards to receptionist to copy)

Primary Insurance | **Subscriber** | **Subscriber Date of Birth**

Secondary Insurance | **Subscriber** | **Subscriber Date of Birth**

Secondary Insurance | **Subscriber** | **Subscriber Date of Birth**

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize my physician and/or administrative and clinical staff of **Connecticut Retina Consultants, LLC** to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, friend)

Name of Person or Entity | **Relationship**

MRN#_____

PATIENT REGISTRATION

I have been provided a copy of the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** to read and understand and consent to use and disclosure of protected health information about myself for treatment, payment and health care operations.

Signature of the Patient or Patient Representative **Relationship to Patient** **Date**

I have been provided a copy of the **Financial Policy** to read. I understand, that I, the patient or the patient's representative, am/is responsible for payment of all charges for services rendered to me, including any balance remaining after payment of insurance benefits. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

Signature of the Patient or Patient Representative **Relationship to Patient** **Date**

I authorize the release of any **medical information** necessary to process all claims. In addition, I authorize direct payment of insurance to **Connecticut Retina Consultants, LLC.**

Signature of the Patient or Patient Representative **Relationship to Patient** **Date**

OFFICE USE

Good faith to obtain written acknowledgement of receipt of the Privacy Practice from the name patient, unable to obtain because:

( ) Patient declined to sign this Written Acknowledgement

( ) Other:_____

Name of Employee **Date**

MRN#_____

PATIENT REGISTRATION

Insurance Referral Policy

I understand that I do not have a **Referral** for today's visit. I understand that I have 72 hours to obtain and fax a referral for today's visit to **Connecticut Retina Consultants, LLC**. If a referral is not obtained and sent, I will be held financially responsible for all services received today. I understand through the terms of my health insurance coverage, it is my responsibility to obtain a referral. If I fail to comply my health insurance may not cover the chargers, cost or expenses related to today's visit.

Signature of the Patient or Patient Representative **Relationship to Patient** **Date**
******Signature required for Lack of Referral Only******

OFFICE USE

Good faith to obtain written acknowledgement of receipt of the Privacy Practice from the name patient, unable to obtain because:

( ) Patient declined to sign this Written Acknowledgement

( ) Other:_____

Name of Employee **Date**

Connecticut Retina Consultants, L.L.C.

MRN#_____

Agreement of Financial Responsibility

Connecticut Retina Consultants would like to thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are contracted providers.

We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.

Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

Please understand some insurance coverages have out of network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an out of network benefit, your portion of financial responsibility may be higher than the in-network rate.

Co-pays: Some plans have required co-payment charges. If your policy has a co-pay you will be required to pay it at the time of service.

Deductibles: All New Patients with high deductible plans will be required to pay **$200.00** at the time of service upon check in. All Establish Patients will also be required to pay **$200.00** at the time of service upon check in at the beginning of the individuals plan year and/or if your plan deductible has not been met.

Co-insurance: Refers to money that an individual is required to pay for services, after a deductible has been paid. If your plan has a co-insurance, we will bill you the co-insurance amount after the insurance has adjudicated your claim.

I have read the financial policies contained above, and my signature below serves as acknowledgment of a clear understanding of my financial responsibilities. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient/Responsible Party **Date**

_____ _____

Name of Patient/Responsible Party (print) **Date**

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CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24-hour notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours' notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hours' notification may be subject to a **$45.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered as **NO SHOW**. Patients who No-Show two (**2**) or more times in a 12-month period, may be dismissed from the practice thus they will be denied any future appointments. Patients may also be subject to a **$45.00** fee for office appointment No Show.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. You also may be required to provide a credit/debit card for our office to securely store on file.

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication.

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

_____ _____

Patient Name (Please Print) **Date of Birth**

_____ _____

Patient/Guardian Signature **Date**

OFFICE USE

MRN #_____

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Office Directions

Bridgeport Office: 4920 Main Street Bridgeport Suite 309, CT 06606

Connecticut 15 South: Take exit 48 (Main Street), at the end of the ramp take a left on Main Street. Go straight through 2 traffic lights (passing Trumbull mall on the right). At the 3rd traffic light take a left onto Old Town Road. Take a left into our parking lot.

Connecticut 15 North: Take exit 48 (Main Street), at the end of ramp take a right onto Main Street. Go straight through 1 traffic light (passing Trumbull mall on right). At the next traffic light take a left onto Old Town Road. Take a left into our parking lot.

I-95 North: Take exit 27A to route 8/25 connector, stay right on 25 at split (following signs to route 15 South) Get onto route 15 South and take exit 48 (Main Street) at the end of the ramp take a left on Main Street. Go straight through 2 traffic lights (passing Trumbull mall on the right). At the 3rd traffic light take a left onto Old Town Road. Take a left into our parking lot.

I-95 South: Take 95 South to exit 38 (connector to Merritt Parkway, Route 15 South). Stay to the left of the connector following signs to Merritt Parkway, Route 15 South. After getting on Route 15 South take exit 48. At the end of ramp take a left onto Main Street. Go straight through 2 traffic lights (passing Trumbull mall on the right). At the 3rd traffic light take a left onto Old Town Road. Take a left into our parking lot.

Norwalk Office: 111 East Avenue Suite 335, Norwalk, CT 06851

I-95 South: Take I-95 to Exit 16. At the end of the exit ramp take a right onto East Avenue. Follow the road down to 111 East Avenue. Park in back.

I-95 North: Take I-95 to Exit 16. At the end of the exit ramp take a left onto East Avenue. Follow the road down to 111 East Avenue. Park in back.

Merritt Parkway South: Take parkway Exit 41. At the end of the ramp take a left. Follow the road to the 1st traffic light and take a left onto Newtown Avenue. Go about 4 miles where the road will merge which becomes Route 53. Continue on the road which becomes 111 East Avenue. Park in the back of the building.

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Office Directions

Hamden Office: 2440 Whitney Avenue Suite 103, Hamden CT, 06518

Connecticut 15 North: Take exit 61. At the end of the exit take a right onto Whitney Avenue. Go past 2 traffic lights and just pass the 3rd light you will see a beige building with 2440 on the top side of the building. Take a left into the parking lot to the back of the building. Enter from the back lobby Suite 103 (office across from the bank entrance).

Connecticut 15 South: Take exit 62. At the end of the exit take a right onto Whitney Avenue. Go past 2 traffic lights and just pass the 3rd light you will see a beige building with 2440 on the top side of the building. Take a left into the parking lot to the back of the building. Enter from the back lobby Suite 103 (office across from the bank entrance).

91 North/South: Take exit 10 to the connector. Take exit 1 (US 5 State Street/Dixwell Avenue). Take a left at the light onto Devine Street. At the next light take a right onto Dixwell Avenue. Go straight on Dixwell to Whitney Avenue intersection (Town Hall will be on the corner). Take a right onto Whitney Avenue. The office will be on the left side just past the next light. It's a beige building 2440 on the top side of the building. Take a left into the parking lot to the back of the building. Enter from the back lobby Suite 103 (office across from the bank entrance).

Madison Office: 6 Woodland Road Suite 2, Madison, CT 06443

I-95 North (From New Haven): Take I-95 North to exit 61 in Madison. Turn right onto Durham Road/CT-79 towards Madison. Take first right onto Woodland Road. The complex is on the right (6 Woodland Road).

I-95 South (From New London): Take I-95 South to exit 61 in Madison. Turn left onto Durham Road/CT-79 towards Madison. Take first right onto Woodland Road. The complex is on the right (6 Woodland Road).

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Office Directions

New Haven Office: 46 Prince Street Suite 203, New Haven, CT 06519

Merritt Parkway: Take Exit 57 onto Route 34. Follow 34 all the way down to Route 10 (Ella Grasso Blvd) and take a right. At the second light take a left onto Legion Avenue. Legion Avenue turns into Frontage Road. Follow through and take a right onto Church Street South. At the second light take a right onto Amistad Street and a right into our parking lot.

I-95 N/S: Follow 95 to Exit 47 (Downtown New Haven/34 Connector), go straight up to the light and take a left onto Church Street South (stay in the right hand lane). At the third light take a right onto Amistad Street and a right into our parking lot.

I-95 South: Follow 91 to exit 1 (Downtown New Haven/34 Connector), go straight up to the light and take a left onto Church Street South (stay in the right hand lane). At the third light take a right onto Amistad Street and a right into our parking lot.

Route 8 South: Take Exit 22 which forks, bare left onto ramp. At the end of the ramp take a left onto Route 67. Follow Route 67 approximately 7 miles to intersection with Route 63. Take a right onto Route 63. Follow Route 63 into downtown New Haven. At the New Haven green take a right onto College Street. Follow College Street through 4 traffic lights. At the fifth light take a left onto Frontage Road. Stay on Frontage Road and at the next light take a right onto Church Street South. At the third light take a right onto Amistad Street and a right into our parking lot.

Pro Park Parking Lot

$3.00 at the kiosk in the main lobby
Please bring your license plate number for your ticket