OFFICE LOCATIONS
748 state st – medford, or 97504
1236 ne 7th st – grants pass, or 97526

p: 541 842 2020
f: 541 842 2022
retinacarecenter.org

retina
CARE CENTER

ADAM AUFDERHEIDE, MD, PhD
LISA LEISHMAN, MD

WELCOME TO OUR OFFICE.

Our practice is committed to providing you with timely care of the highest standards and with the utmost attention to your individual needs. We understand that your sight is precious. We are fully committed to helping you understand your disease and your treatment options. We will strive to provide you with the personalized care you deserve.

YOUR INITIAL APPOINTMENT.

Your first visit may last 2 to 4 hours, depending on the need for special testing and treatment. **We suggest that someone drive you to and from our office since both of your eyes will be dilated for your examination.** If treatment of one of your eyes is required, that eye may be patched overnight.

Please bring a list of all Current Medications (with daily dosage) and your insurance cards to your appointment.

EXPERIENCE: The providers at Retina Care Center are all board-certified ophthalmologists, specializing and fellowship trained in the medical and surgical treatment of diseases affecting the vitreous, macula, and retina.

Adam AufderHeide, MD, PhD is a highly accomplished medical professional, specializing in the field of vitreoretinal surgery. He obtained his Bachelor of Science degree in Mechanical Engineering from the prestigious Rose-Hulman Institute of Technology in 2001, with minors in Applied Biology and Biomedical Engineering, graduating Summa Cum Laude. Dr. AufderHeide went on to earn his Ph.D. in Bioengineering from Rice University in 2007, followed by an M.D. degree from Baylor College of Medicine in 2010. From 2011 – 2014, Dr. AufderHeide completed his residency in Ophthalmology at the University of Kansas, KU Eye in Kansas City, Kansas, and then distinguished himself by completing a 2-year Vitreoretinal Fellowship at the World-renowned Charles Retina Institute and University of Tennessee College of medicine in 2016.

Lisa Leishman, MD is a highly accomplished ophthalmologist, boasting an impressive education and extensive professional experience in the field. Having graduated with an M.D. from the University of Utah Medical School in 2011, she completed a Fellowship in Intraocular Lens Research & Ocular Pathology at the Moran Eye Center in 2013. Later that year, she returned to the University of Utah where she completed an Internship in Internal Medicine. In 2016, Dr. Leishman completed an Ophthalmology Residency at the University of Missouri, Columbia Missouri. She then went on to complete a Cornea Fellowship at Laser and Cornea Surgery Associates PC, New York Eye and Ear Infirmary, Mount Sinai in 2018. Lisa Leishman, MD completed a 2-year Vitreoretinal Fellowship in 2020 at Retina Consultants, LTD and Cook County Hospitals in Chicago, IL. Throughout all of these intense and specialized programs, Dr. Leishman received world-class training and mentorship in the field of ophthalmology.

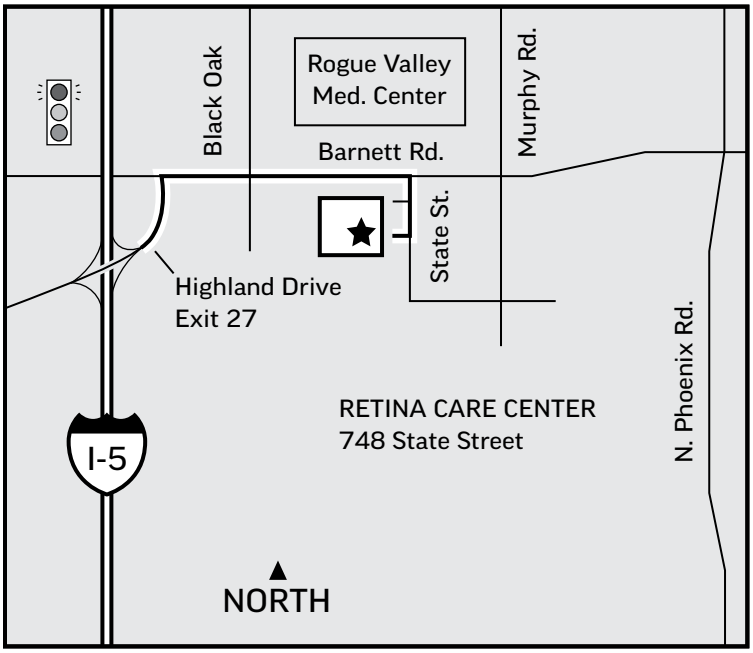
Your appointment ▶ Day: _____ Date: _____ Time: _____

☐ **Medford Office** ☐ **Grants Pass Office**

Please fill out both sides of the attached forms and bring them with you. See reverse side for maps.

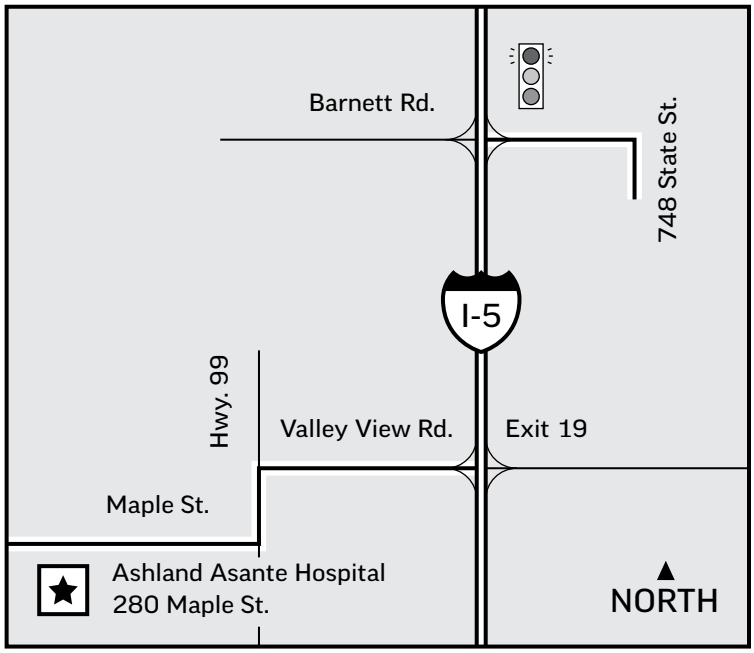
MEDFORD OFFICE – 748 State Street

From I-5, take South Medford Exit 27.
Turn Right onto Barnett Road. Drive 1 mile.
Turn Right onto State Street (across from ARRMC).
748 State Street is the first building on the right.
Please use the second parking lot entrance.



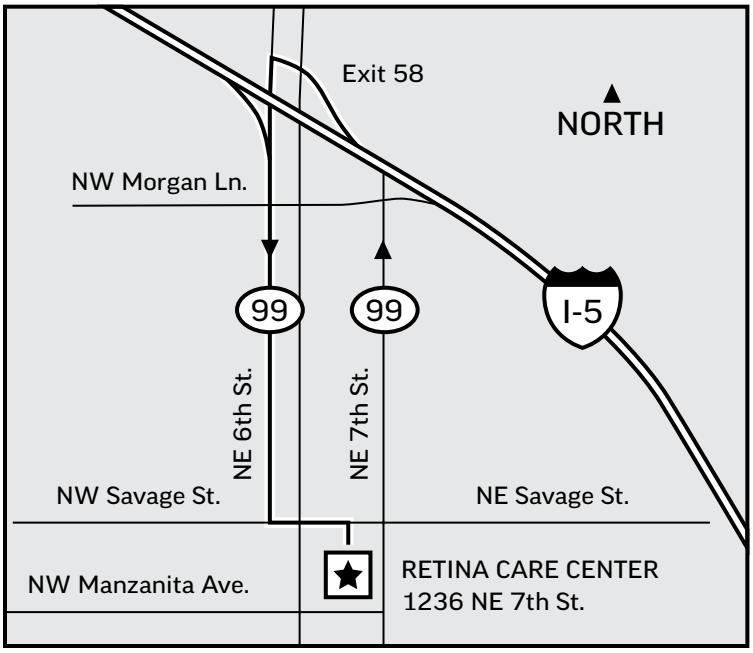
ASANTE ASHLAND HOSPITAL – 280 Maple

From I-5, take Ashland Exit 19.
Turn West at stop sign onto Valley View Road.
Turn Left onto Highway 99.
Turn Right onto Maple Street.
Hospital is on Left at top of hill.



GRANTS PASS OFFICE – 1236 NE 7th Street

From I-5, take OR-99, Redwood Hwy Exit 58.
Travel South on 6th Street for approx. 1 mile (3 stop lights).
Turn Left on Savage Street.
Turn Right at the last parking lot entrance on the Right.
You will see a "Retina Care Center" sign on Left.



Please fill out both sides of this form and return to the receptionist at your appointment.

REGISTRATION FORM
SIDE 1

ADAM AUFDERHEIDE, MD, PhD
LISA LEISHMAN, MD

Name: Social Security No.:

Date of Birth: Age: Sex:

Address: City, State & Zip:

Email: Home Phone: Cell Phone:

Occupation: Employer:

Work Address: Work Phone:

Spouse's Name: Spouse's Employer:

Spouse's Work Address: Spouse's Work Phone:

If under 18 years, name of mother/father/guardian:

NOTIFY IN CASE OF EMERGENCY (Name): Relationship: Phone:

NAME OF PRIMARY INSURANCE:

Subscriber's Name: Date of Birth:

Subscriber's Policy No.: Group No.:

NAME OF SECONDARY INSURANCE:

Subscriber's Name: Date of Birth:

Subscriber's Policy No.: Group No.:

Your Ophthalmologist (eye MD): Phone:

Your Optometrist (OD): Phone:

Your Primary Care Provider: Phone:

Your Specialist MD: Phone:

Preferred Language:

RACE

☐ American Indian or Alaska Native: Origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
☐ Asian: Origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
☐ Black or African American: Origins in any of the black racial groups of Africa.
☐ Native Hawaiian or Other Pacific Islander: Origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.
☐ White: Origins in any of the original peoples of Europe, the Middle East or North Africa.

ETHNICITY

☐ Hispanic or Latino: Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
☐ Non-Hispanic or Latino: Paitient is not of Hispanic or Latino ethnicity.

☐ I **refuse to report this information.**

REGISTRATION FORM
SIDE 2

ADAM AUFDERHEIDE, MD, PhD
LISA LEISHMAN, MD

I give permission to the Retina Care Center to bill my insurance company whether the benefits are to come to me or to the Retina Care Center. I further authorize the Retina Care Center to release or fax any information needed to determine what benefits may be payable for services rendered or to communicate with medical facilities involved in my care. It is my understanding that I am eligible for medical benefits through my insurance (e.g. Medicare, Medicaid, Blue Cross/Blue Shield or other private insurance companies). However, in the event that my insurance company categorizes services rendered to me as "non-covered" or "not medically necessary," I agree to pay in full for such charges. I fully understand that it is my responsibility to advise the Retina Care Center if my insurance requires pre-admission review, pre-admission authorization, second opinion or if it contains any special provisions (to include exclusionary riders) which must be satisfied before payment by my insurance company can be made. If I do not comply with said requirements, I agree to pay in full all balances due.

If I am a member of a managed care plan, I understand that it is my responsibility to make sure the correct referral is in place from my Primary Care Provider. I understand I will be financially responsible for any and all charges at the time of service should a referral not be supplied by my Primary Care Provider. For individuals with private insurance, **the signature below** authorizes direct assignment of benefits to the Retina Care Center.

I acknowledge that Retina Care Center informed me in advance of my examination that my eyes will be dilated and that driving while my eyes are dilated may be hazardous. They instructed me to make arrangements so I would not have to drive after my appointment. If I choose to drive after any appointment when my eyes have been dilated, I agree to take full responsibility for damage or injury to myself or others, and release Retina Care Center from any liability. I also agree to defend Retina Care Center against any claim and assume responsibility for any damages or expenses, including the cost of attorney fees, resulting from my driving while dilated.

SIGNATURE: _____ DATE: _____

Please fill out both sides of this form and return to the receptionist at your appointment.

MEDICAL HISTORY FORM
SIDE 1

ADAM AUFDERHEIDE, MD, PhD
LISA LEISHMAN, MD

Name:

Date: Date of Birth: Age:

EYE HISTORY

Eye Disease:
☐ No ☐ Yes

Type:
☐ Retinal ☐ Glaucoma
☐ Cataract ☐ Amblyopia or "Lazy Eye"
☐ Other
If other, please explain:

Eye Surgery:
☐ No ☐ Yes

Type and Dates:
☐ Retinal ☐ Cataract
☐ Glaucoma ☐ Enucleation
☐ Other
If other, please explain:

Eye Injury:
☐ No ☐ Yes

If yes, please explain:

EYE SYMPTOMS

Reduced or Blurred Vision	☐ No ☐ Yes	☐ right ☐ left
Distorted Vision	☐ No ☐ Yes	☐ right ☐ left
Double Vision	☐ No ☐ Yes	☐ right ☐ left
Flashing Lights	☐ No ☐ Yes	☐ right ☐ left
Floaters	☐ No ☐ Yes	☐ right ☐ left
Glare	☐ No ☐ Yes	☐ right ☐ left
Light Sensitivity	☐ No ☐ Yes	☐ right ☐ left
Redness	☐ No ☐ Yes	☐ right ☐ left

EYE MEDS/DOSAGES

_____ ☐ right ☐ left prescribed by:

_____ ☐ right ☐ left prescribed by:

MEDICAL HISTORY

Do you or have you had any of the following problems? (if yes, please describe)

Diabetes Type I (insulin dependent)	☐ No ☐ Yes	Duration:	Recent blood sugar: Recent Ha1C:
Diabetes Type II (no insulin)	☐ No ☐ Yes	Duration:	Recent blood sugar: Recent Ha1C:
High Blood Pressure	☐ No ☐ Yes		
Heart Disease	☐ No ☐ Yes		
Lung Disease, Asthma or Emphysema	☐ No ☐ Yes		
Kidney Disease	☐ No ☐ Yes		
Stroke	☐ No ☐ Yes		
Arthritis	☐ No ☐ Yes		
Cancer	☐ No ☐ Yes	Type:	Diagnosed date:
Other	☐ No ☐ Yes	List:	

DATE REVIEWED: REVIEWED BY:

MEDICAL HISTORY FORM
SIDE 2

ADAM AUFDERHEIDE, MD, PhD
LISA LEISHMAN, MD

SURGICAL HISTORY (include dates): _____

Coumadin
☐ No ☐ Yes (reason taking) _____

Flomax
☐ No ☐ Yes (reason taking) _____

Amiodarone
☐ No ☐ Yes (reason taking) _____

Plaquenil
☐ No ☐ Yes (reason taking) _____

ALLERGIES TO MEDICATIONS:

FAMILY HISTORY:

Retinal Detachment	☐ No ☐ Yes	Family member:
Macular Degeneration	☐ No ☐ Yes	Family member:
Glaucoma	☐ No ☐ Yes	Family member:
Cataract	☐ No ☐ Yes	Family member:
High Blood Pressure	☐ No ☐ Yes	Family member:
Diabetes	☐ No ☐ Yes	Family member:
Cancer	☐ No ☐ Yes	Family member:

SOCIAL HISTORY:

Smoker (currently or ever been)	☐ No ☐ Yes (if yes, list packs/day and duration) _____
	Year stopped if previous smoker _____
Alcohol	☐ No ☐ Yes (if yes, list amount/day) _____
Hobbies	☐ No ☐ Yes _____
Live Alone	☐ No ☐ Yes
Drive Auto	☐ No ☐ Yes
Require Assistance in daily living	☐ No ☐ Yes
Fall Risk (1 or more falls in current yr)	☐ No ☐ Yes
Work	☐ No ☐ Yes (describe) _____

REVIEW OF SYSTEMS: Do you or have you had any of the following problems? **(if yes, please circle)**

Constitutional	☐ No ☐ Yes – unexpected weight loss/gain, fatigue, chronic fever
Ear, Nose or Throat	☐ No ☐ Yes – hearing loss, ear ringing, sinus problems, sore throat, hoarse
Heart	☐ No ☐ Yes – chest pain, irregular heart beat, short of breath when walking
Respiratory	☐ No ☐ Yes – shortness of breath, wheezing, coughing, sputum production
Gastrointestinal	☐ No ☐ Yes – heartburn, abdominal pain, diarrhea, vomiting, blood in stool
Urinary	☐ No ☐ Yes – pain/discomfort, increased frequency, blood in urine, discharge
Endocrine	☐ No ☐ Yes – increase frequency drinking water and urination, weight loss
Musculoskeletal	☐ No ☐ Yes – muscle aches, joint pain, swollen joints
Neurologic	☐ No ☐ Yes – headache, numbness, weakness, paralysis
Psychiatric	☐ No ☐ Yes – depression, anxiety, PTSD