

Dear Patient,

We would like to welcome you to our practice! In order to expedite your initial visit with us, we are enclosing a new patient packet. Please complete it and bring it along with the items listed below. **Please arrive at your appointment time** and note that the initial appointment may last up to 2 hours.

We look forward to meeting you. Call us at **(313) 441-2227** if you have any questions.

Please bring:

1. Identification Card (ID)
2. Insurance Card
3. Medication List
4. Insurance Referral (if necessary)
5. Sunglasses
6. Driver (your eyes will be dilated during your visit)

**Appointment Information**

**Day:**  Monday  Tuesday  Wednesday  Thursday  Friday

**Date:**        /        /

**Time:**        :         AM         PM

**Location:**

**Dearborn**  
25230 Michigan Ave  
Dearborn, MI 48124  
*(Location on north side of Michigan Ave, between Telegraph and Gulley)*

**Ann Arbor**  
Reichert Health Building  
5333 McAuley Dr, Ste #1018  
Ypsilanti, MI 48197  
*(On campus of St. Joseph Mercy Hospital, Free parking in Lot J)*

Date: \_\_\_\_\_

**Patient Information:**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Age: \_\_\_\_\_ Gender:  Male  Female

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Preferred Phone:  Home  Cell Email: \_\_\_\_\_

Patient's Language Preference: \_\_\_\_\_

**Yes**  **No** || Is the patient currently in a **Skilled Nursing or Rehab Facility** or in **Hospice**?

**Race/Ethnicity:**  African American/Black  Native American  
 Asian  Pacific Islander  
 Caucasian/White  Other: \_\_\_\_\_  
 Hispanic/Latino

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**Emergency Contact:**

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Phone Number: \_\_\_\_\_

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**Other Providers:**

Referring Ophthalmologist/Optomtrist: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Address: \_\_\_\_\_



**Insurance:**

Primary Insurance Provider: \_\_\_\_\_ Policy #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Secondary Insurance Provider: \_\_\_\_\_ Policy #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Effective Date: \_\_\_\_\_

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**Injury:**

*If patient is being seen due to an injury at work or an auto accident, please inform the front desk*

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**Preferred Pharmacy Name:** \_\_\_\_\_

Location: \_\_\_\_\_ Phone: \_\_\_\_\_

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**Patient or Authorized Person Signature:**

I certify the above information is true and accurate. I authorize the release of any medical or other information necessary to process a claim or continue medical treatment. I also authorize payment of medical benefits paid directly to Michigan Retina Center. I acknowledge I am responsible for payment of any balance my insurance company does not pay.

**X** \_\_\_\_\_

Patient or Authorized Person Signature

\_\_\_\_\_

Date

Today's Date: \_\_\_\_\_

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Which symptoms are you experiencing?**

**Mark all that apply**

- Blurry Vision
- Loss of Vision
- Distortion of Vision
- Floaters
- Flashes
- Pain
- Other: \_\_\_\_\_

**Which eye?**

- Right
- Left
- Both

**Severity**

- Mild
- Moderate
- Severe

**Did the symptoms start...**

- Suddenly
- Gradually

**How long ago did your symptoms start?** \_\_\_\_\_ (#) hours / days / weeks / months / years

**Select all diagnoses and surgeries that apply to you, presently and past:**

- |   |           |   |           |            |
|---|-----------|---|-----------|------------|
| <input type="checkbox"/> Macular Degeneration | Eye _____ | <input type="checkbox"/> Cataract Surgery | Eye _____ | Date _____ |
| <input type="checkbox"/> Retinal Tear         | Eye _____ | <input type="checkbox"/> Retinal Surgery  | Eye _____ | Date _____ |
| <input type="checkbox"/> Retinal Detachment   | Eye _____ | <input type="checkbox"/> Glaucoma Surgery | Eye _____ | Date _____ |
| <input type="checkbox"/> Retinal Injections   | Eye _____ | <input type="checkbox"/> Lasik Surgery    | Eye _____ | Date _____ |

**Please list any eye related medications and drops you are currently taking:**

<i>Name or Cap Color</i>	<i>How many times a day?</i>	<i>Which eye?</i>

**Medical History**

- Y  N Flu Vaccine (for current or upcoming flu season)
- Y  N Pneumonia Vaccine
- Y  N Diabetes.  Type 1  Type 2 Last HbA1c \_\_\_\_\_. On Insulin?  Y  N
- Y  N High Blood Pressure
- Y  N Rheumatoid Arthritis. Do you take Plaquenil?  Y  N. If yes, dosage: \_\_\_\_\_
- Y  N Kidney Disease. Are you on dialysis?  Y  N. Which Days: \_\_\_\_\_



Do you have any drug allergies?  Y  N \_\_\_\_\_

**Smoking History**

- None
- Current Smoker
- Former Smoker

**Alcohol Use**

- Never
- Occasionally, Socially
- Multiple Drinks Per Day

**Recreational Drug Use**

- No
- Marijuana
- Other: \_\_\_\_\_

**Family History:** (list family members)

- None
- Blindness –
- Retinal Detachment –
- Macular Degeneration –
- Cataract –
- Stroke –
- Heart Attack –
- Cancer –
- Glaucoma –
- Diabetes –

**Review of Systems:** Please check if you currently have any of the following symptoms

- |                         |  |  |   |
|-------------------------|--|--|---|
| <b>Cardiovascular</b>   | <input type="checkbox"/> Chest Pain                | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Swelling of Feet       |
| <b>Constitutional</b>   | <input type="checkbox"/> Fever                     | <input type="checkbox"/> Weight Loss         | <input type="checkbox"/> Fatigue                |
| <b>Endocrine</b>        | <input type="checkbox"/> Excess Thirst             | <input type="checkbox"/> Excessive Urination | <input type="checkbox"/> Heat/Cold Intolerance  |
| <b>Gastrointestinal</b> | <input type="checkbox"/> Abdominal Pain            | <input type="checkbox"/> Diarrhea            |   |
| <b>Genitourinary</b>    | <input type="checkbox"/> Pain/Burning on Urination | <input type="checkbox"/> Blood in Urine      |   |
| <b>Hematology</b>       | <input type="checkbox"/> Easy Bruising             | <input type="checkbox"/> Prolonged Bleeding  | <input type="checkbox"/> Past Blood Transfusion |
| <b>Ear/Nose/Throat</b>  | <input type="checkbox"/> Hearing Loss              | <input type="checkbox"/> Sore Throat         | <input type="checkbox"/> Runny Nose             |
| <b>Integumentary</b>    | <input type="checkbox"/> Rash                      | <input type="checkbox"/> Change in Mole      |   |
| <b>Musculoskeletal</b>  | <input type="checkbox"/> Muscle Aches              | <input type="checkbox"/> Joint Pain          | <input type="checkbox"/> Difficulty Laying Flat |
| <b>Neurologic</b>       | <input type="checkbox"/> Dizziness                 | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Scalp Tenderness       |
| <b>Respiratory</b>      | <input type="checkbox"/> Wheezing                  | <input type="checkbox"/> Cough               | <input type="checkbox"/> Coughing Blood         |

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
History Review: Physician Signature

\_\_\_\_\_  
Date

For Purposes of

**Treatment, Payment and Healthcare Operations**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. Each patient must read our Notice of Privacy Practices and return their signed acknowledgment of their receipt. This acknowledgement must be filed in the patient’s chart.

I hereby consent to Michigan Retina Center, my health care provider, using or disclosing my protected health information for the purpose of providing health care treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice’s health care operations.

The full Notice of Privacy Practices provides a more detailed description of the uses and disclosures allowed by this consent. I acknowledge a copy of the Notice of Privacy Practices has been made available to me. I understand the Practice reserves the right to change the privacy practices and that I can obtain a revised copy of the notice at the front desk.

I understand that I can request restrictions on the way my health care information is used and disclosed, but I also understand that the Practice is not required to agree to any of my restrictions, but if it does, the restriction is binding on the Practice.

This authorization will remain in effect until written notice of revocation is received. I understand that I can revoke this consent in writing, at any time, but that this revocation will not apply to uses of my records between the date of this consent and the date of revocation.

**\*I authorize Michigan Retina Center to disclose medical records to:**

**Patient Advocate Name(s)/Relationship:** \_\_\_\_\_

\_\_\_\_\_

Patient Name

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Patient, Parent, or POA

\_\_\_\_\_

Witness Signature

***For Office Use Only***

\_\_\_\_\_ Michigan Retina Center made a “*good faith*” effort to obtain the individual’s acknowledgment of the Notice of Privacy Practice.

\_\_\_\_\_

Signature of Practice Representative

\_\_\_\_\_

Date