MICHIGAN
RETINA
CENTER

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
(*Located on north side of Michigan Ave, between Telegraph and Gulley*)

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

❑ **Novi**
24520 Meadowbrook Rd, Suite 100
Novi, MI 48375
(Located on east side of Meadowbrook Rd, between 10 Mile Rd and Grand River)

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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
- ❑ Asian
- ❑ Caucasian/White
- ❑ Hispanic/Latino
- ❑ Native American
- ❑ Pacific Islander
- ❑ Other: _____

Emergency Contact:

Emergency Contact Name: _____ Relationship: _____

Emergency Phone Number: _____

Other Providers:

Referring Ophthalmologist/Optometrist: _____

Phone:_____ Fax: _____ Address:_____

Primary Care Physician:_____

Phone:_____ Fax: _____ Address:_____

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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:_____

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:_____

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

MICHIGAN RETINA CENTER

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, <u>presently</u> and <u>past</u>, and indicate for which eye(s):

- ❑ Macular Degeneration Eye_____
- ❑ Retinal Tear Eye_____
- ❑ Retinal Detachment Eye_____
- ❑ Retinal Injections Eye_____
- ❑ Cataract Surgery Eye_____
- ❑ Retinal Surgery Eye_____
- ❑ Glaucoma Surgery Eye_____
- ❑ Lasik Surgery Eye_____

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

Name or Cap Color	*How many times a day?*	*Which eye?*

Check Y or N for the following:

❑ Y ❑ N **Flu Vaccine** (for current or upcoming season)

❑ Y ❑ N **Pneumonia Vaccine**

❑ Y ❑ N **Diabetes** *If yes, which type?* ❑ Type I ❑ Type II

Are you on insulin: ❑ Y ❑ N

*What was last HbA1c:*_____

❑ Y ❑ N **High Blood Pressure**

❑ Y ❑ N **Rheumatoid Arthritis** *If yes, do you take plaquenil?* ❑ Y ❑ N

Indicate dosage: _____

❑ Y ❑ N **Kidney Disease** *If yes, are you on dialysis?* ❑ Y ❑ N

*Indicate which days:*_____

Medical History Continued:

❑ Y ❑ N **Heart Problems**	❑ Heart Attack	❑ Angina	❑ Arrhythmia	❑ Heart Failure
❑ Y ❑ N **Neurology**	❑ Stroke	❑ Seizures	❑ Alzheimer's	
	❑ Neuropathy	❑ Parkinson's	❑ Migraine	
❑ Y ❑ N **Endocrine**	❑ Hyperthyroidism	❑ Hypothyroidism	❑ High Cholesterol	
❑ Y ❑ N **Pulmonary**	❑ Asthma	❑ COPD	❑ Pulmonary Embolism	
	❑ Tuberculosis			
❑ Y ❑ N **Genitourinary**	❑ Kidney Stones	❑ Enlarged Prostate		
❑ Y ❑ N **Gastroenterology**	❑ GERD/Reflux	❑ IBS	❑ Crohn's	
	❑ Diverticulitis	❑ Ulcers		
❑ Y ❑ N **Hematology**	❑ Anemia	❑ Hepatitis	❑ HIV	❑ Sickle Cell
	❑ Lyme Disease	❑ Cancer:_____		
❑ Y ❑ N **Rheumatology**	❑ Sjogren's	❑ Lupus	❑ Autoimmune Disorder:_____	
❑ Y ❑ N **Psychiatry**	❑ Depression	❑ Anxiety		
❑ Y ❑ N **Surgical History**	❑ Cardiac Bypass	❑ Heart Stent	❑ Pacemaker	
	❑ Lung Surgery	❑ Kidney Surgery	❑ Other:_____	

❑ Y ❑ N **Other Diagnoses Not Listed Above:** _____

Check any of the following medications you currently take:
❑ Coumadin/Warfarin ❑ Eliquis ❑ Plavix ❑ Xarelto

Please list <u>all</u> other current medications you are taking
(Prescription, over the counter, herbal, and supplements)

Name	Dose/Frequency	Name	Dose/Frequency

Do you have any drug allergies? ❑ Y ❑ N *If yes, please list them:*_____

Smoking History
- ❑ None
- ❑ Current Smoker
- ❑ Former Smoker

Alcohol Use
- ❑ Never
- ❑ Occasionally, Socially
- ❑ Multiple Drinks Per Day

Recreational Drug Use
- ❑ None
- ❑ 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

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

X_____ _____

Patient or Authorized Person Signature Date

X_____ _____

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