

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

Emergency Contact:

Emergency Contact Name: _____ Relationship: _____

Emergency Phone Number: _____

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: _____

Injury:

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

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

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:

Right Left

- Macular Degeneration
- Retinal Tear
- Retinal Detachment
- Retinal Injections

Right Left

- Cataract Surgery
- Retinal Surgery
- Glaucoma Surgery
- Lasik Surgery

Date: _____
Date: _____
Date: _____
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)

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