

Registration :

Date	Account ID	Chart ID	Other ID	Internal Use
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Patient Information							
Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #
Address			Home:		How did you hear of us?		
Address 2			Work:				
			Cell:				
			Email:				
City	State	Zip Code	Employer Name & Address			Occupation	
Emergency Contact		Phone	Pharmacy			Pharmacy Phone	

Physician	Family Physician	Referring Physician
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Medical Insurance	Name & Address	Policyholder	Relationship	Copay	Policy ID	Group ID
1						
2						
3						

Guarantor (Person to be billed, if different than patient)							
1	Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
Address			Home:		Work:	Email:	
City			State	Zip Code	Employer Name & Address		Occupation
2.	Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
Address			Home:		Work:	Email:	
City			State	Zip Code	Employer Name & Address		Occupation

HIPAA Approved Contacts							
1.	Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship
Address		City	State	Zip Code	Home:	Cell:	Work:

Is this auto related? yes / no Is this work related? yes / no

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Glaucoma Center Of Michigan , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date	Glaucoma Center Of Michigan 29201 Telegraph Rd., Suite 301 Southfield, MI 48034	Phone: 248-356-1321 Email:
X			

Please attach all pertinent insurance ID cards for photocopying.



GLAUCOMA CENTER OF MICHIGAN
INSURANCE AND FINANCIAL INFORMATION

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

REGARDING INSURANCE

We participate with most commercial insurance companies. If you do not completely understand your insurance policy or have questions regarding covered services, we encourage you to call your insurance company prior to your visit. The services rendered will be billed under your **medical – NOT vision benefits**. Exceptions are Co/op Optical, and SVS-Ford Programs. You must bring with you all proper insurance information necessary for us to bill your insurance company. If your insurance policy has unmet deductible amounts, payment at the time of service is expected.

There are many types of commercial insurance companies. Please be advised that HMOs require a written referral from your primary care physician, **not the physician who referred you to our office**. **You must have your referral in hand at the time of your visit, or you will be asked to reschedule your appointment until the referral is obtained**. Providing we participate, most PPOs require a co-payment at the time of your visit. Payment is due at the time of service. Please contact your insurance company to see if we are a participating physician.

Please be aware some and perhaps all of the services provided may be "**NON-COVERED**" services. **This also applies to HMO policies even if authorized by your Primary Care Physician**. These services may also be applied to your yearly deductible or require a co-payment. **Most insurance companies DO NOT pay for services at 100 percent**. Any disputes regarding payment are up to you to resolve with the insurance company.

Please help us serve you better by keeping scheduled appointments or give us 24 hours' notice if you need to cancel. Cancellations with less than 24 hours' notice or failure to show up for any scheduled appointment may result in a fee.

FAILING TO COMPLY WITH THESE SUGGESTIONS COULD RESULT IN YOU, THE PATIENT, BEING RESPONSIBLE FOR PAYMENT IN FULL.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. We would be more than happy to provide you with assistance. You can contact our office Monday thru Friday, 9:00 a.m. until 4:30 p.m., at (248) 356-1321.

I have read the Financial Policy (above). I understand and agree to the Financial Policy:

Signature - Patient or Responsible Party Date: _____

Signature - Co-Responsible Party Date: _____

**WE ACCEPT CASH, CHECK, MONEY ORDER AND
VISA / MASTER CARD / DISCOVER / AMERICAN EXPRESS**

MEDICAL HISTORY QUESTIONNAIRE

DATE _____

NAME _____ DATE OF BIRTH _____

REFERRING EYE DOCTOR: _____ PHONE: _____
ADDRESS: _____

City _____ State _____ Zip _____

MEDICAL DOCTOR: _____ PHONE: _____
ADDRESS: _____

City _____ State _____ Zip _____

ARE YOU BEING TREATED FOR GLAUCOMA? YES NO IF YES HOW LONG? _____

WHAT MEDICATIONS ARE YOU ON FOR YOUR EYES?

PLEASE LIST ALL OTHER MEDICATIONS (Including Vitamins):

DO YOU TAKE DIAMOX OR NEPTAZANE FOR YOUR EYE PRESSURE? YES NO (Please circle which one)

HAVE YOU HAD ANY SURGERY ON YOUR EYES? YES NO WHAT? _____

PLEASE LIST **ALL** OTHER SURGERIES YOU HAVE HAD: **(NOT EYE SURGERY)**

CATARACT SURGERY? YES NO WHEN? _____

GLAUCOMA SURGERY? YES NO WHEN? _____

HAVE YOU HAD ANY LASER TREATMENTS ON YOUR EYES? YES NO WHEN? _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO WHICH DRUGS? _____

IS THERE ANY FAMILY HISTORY OF GLAUCOMA? YES NO IF YES WHO? _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

DIABETES YES NO HOW LONG? _____

HAVE YOU EVER USED STERIOD DRUGS? YES NO (CORTISONE/PREDNISONE)

HIGH BLOOD PRESSURE YES NO HOW LONG? _____

ASTHMA / EMPHYSEMA YES NO HOW LONG? _____

KIDNEY STONES YES NO HOW LONG? _____

MIGRAINE HEADACHES YES NO HOW LONG? _____

ANGINA YES NO WHEN? _____

HIV YES NO HOW LONG? _____

HEART ATTACK YES NO WHEN? _____

TB YES NO HOW LONG? _____

STROKE YES NO WHEN? _____

HEPATITIS YES NO HOW LONG? _____
DO YOU SMOKE? YES NO IF YES
Please Circle - Occasional / Regularly _____ pack(s) per day

HAVE YOU EVER BEEN IN SHOCK? YES NO WHEN? _____

DO YOU DRINK ALCOHOL? YES NO IF YES
Please Circle - Occasional / Regularly _____ drink(s) per day

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO WHEN? _____

ARE YOU BEING TREATED FOR ANY OTHER CONDITION NOW? YES NO IF YES - WHAT? _____

PLEASE SEE THE OTHER SIDE TO REVIEW OTHER CONDITIONS

Medical History Questionnaire reviewed by Physician _____
PHYSICIAN SIGNATURE

PATIENT NAME: _____

DATE: _____

REVIEW OF SYSTEMS: If you are currently having any problems in the following areas, circle and explain (if necessary).

CONSTITUTIONAL SYMPTOMS: (e.g., fever, weight loss, weight gain, unusually tire)

Explain: _____

SKIN: (Itching, rash, infection, ulcer, tumors {growths}, other)

Explain: _____

BLOOD / LYMPH NODES: (Bleeding, cholesterolemia, anemia, problems, problems related to blood transfusions, etc.)

Explain: _____

BONES, JOINTS, MUSCLES: (Muscle pain/cramps, joint pain/swelling, stiffness, arthritis, other)

Explain: _____

ENDOCRINE: (Fatigue, confusion fainting, nervousness, hot/cold intolerance, hair loss, excessive hair growth, diabetes, hypothyroid, other)

Explain: _____

ALLERGY/IMMUNOLOGY: (Recurrent infections, hay fever, hives, food allergy, drug sensitivity/allergy, other)

Explain: _____

EARS, NOSE, THROAT: (Hard of hearing, stuffy nose, earache, cough, dry mouth etc.)

Explain: _____

RESPIRATORY: (Wheezing cough {productive/ blood}, difficulty breathing, other)

Explain: _____

CARDIOVASCULAR (HEART/BLOOD VESSELS): (Chest pain, cold hands/feet, swelling of extremities, shortness of breath, exercise intolerance, high blood pressure, other)

Explain: _____

GASTROINTESTINAL (stomach/intestines): (Nausea, vomiting, change in bowel habits, Constipation, diarrhea, bleeding, pain/cramps, other)

Explain: _____

GENITOURINARY (genitals/kidneys/bladder): (Frequency, burning, hesitancy, pain or bleeding on urination, stones, infections, incontinence, impotence, other)

Explain: _____

FEMALES: Are you pregnant? Yes / No Nursing? Yes / No

BREASTS: (Tenderness, swelling, lumps, discharge, other)

Explain: _____

NEUROLOGICAL: (numbness, dizziness, vertigo, headache, seizures, paralysis, etc.)

Explain: _____

PSYCHIATRIC: (Disorientation, mood swings, anxiety, depression, hallucinations, other)

Explain: _____

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (Circle all that apply) YES NO UNKNOWN

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Other heritable disease: _____

SIGNATURE OF PATIENT _____

OVER