PATIENT INFORMATION

Name:_____ Home Phone:_____

Address:_____ Work Phone:_____

City:_____ State:_____ Zip:_____

SSN:_____ Sex (M/F)_____ E-Mail:_____

(office use only)

Date of Birth:_____ Marital Status: S M W D

Employed? YES _____ NO_____ Employer:_____

INSURANCE

Who is the insurance through? SELF_____ SPOUSE_____ OTHER_____
If other than self, name of Subscriber:_____
Relationship:_____ Date of Birth:_____ SSN:_____
Employer of Subscriber:_____
Employer Address:_____

Medicare #:_____ **Medicaid #:**_____

Blue Shield:
Cardholder Name:_____ Contract #:_____
Policy/Group#:_____ Insurance Phone #:_____

Other Insurance:
Name of Insurance:_____
Cardholder Name:_____ Contract #:_____
Policy/Group#:_____ Insurance Phone #:_____
Address of Insurance:_____

Do you have Vision Insurance: YES_____ NO_____
Is this Worker's Compensation: YES_____ NO_____ If yes, date of injury:_____

Referring Physician:_____

Address:_____ Phone #:_____

I HEREBY AUTHORIZE THE RELEASE OF THE NECESSARY MEDICAL INFORMATION TO PROCESS INSURANCE CLAIMS AND DIRECT PAYMENT OR BENEFITS TO THE PHYSICIAN RENDERING SERVICE. I AM RESPONSIBLE TO PAY NON-COVERED SERVICES, CO-PAYS, AND DEDUCTIBLES.

Patient Signature:_____ **Date:**_____

Subscriber Signature:_____ **Date:**_____

EMERGENCY CONTACT: Name:

PHONE NUMBER: RELATIONSHIP TO YOU:

MEDICAL HISTORY

NAME _____ BIRTHDATE _____

PRIMARY CARE PHYSICIAN _____ CITY _____ PHONE# _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR MEDICAL STATUS AND HISTORY:

1. Have you ever been treated for any medical conditions (diabetes, high blood pressure, arthritis, etc)
   YES____ NO____ If YES, please explain: _____
2. Are you being treated for Glaucoma or any other eye disease (cataract, retinal problems)
   YES____ NO____ If YES, please explain: _____
3. Have you ever had any surgery (including glaucoma or cataract surgery)
   YES____ NO____ If YES, please provide date and reason _____
4. Do you take any medications? (including steroids/prednisone)
   YES____ NO____ If YES, please list _____
5. Do you take any eye medications? (including Diamox or Neptazane pills)
   YES____ NO____ If Yes, please list _____
6. Do you have any drug or food allergies:
   YES____ NO____ If YES, please list _____

REVIEW OF SYSTEMS

Do you currently have any of the following problems:	YES	NO	IF YES, PLEASE EXPLAIN
Chronic fever, unexpected weight loss/gain, fatigue	____	____	_____
Ear/nose/throat problems (sinus problems, sore throat, hearing loss)	____	____	_____
Heart Problems (chest pain, irregular heart beat, heart attacks)	____	____	_____
Respiratory problems (shortness of breath, wheezing, coughing, asthma, emphysema)	____	____	_____
Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting)	____	____	_____
Urinary problems (pain or discomfort, blood in urine, kidney stones)	____	____	_____
Skin problams (rashes, excessive dryness)	____	____	_____
Musculoskeletal problems (muscle aches, joint pain, swollen joints)	____	____	_____
Neurologic problems (migraine headaches, numbness, weakness, strokes)	____	____	_____
Psychiatric problems (depression, anxiety)	____	____	_____
Do you have high blood pressure?	____	____	_____
Do you have diabetes?	____	____	_____
Have you had a blood transfusion?	____	____	_____
Have you ever gone into shock?	____	____	_____

FAMILY AND SOCIAL HISTORY

Do you smoke? YES____ NO____ If YES, how much?
Do you drink alcohol? YES____ NO____ If YES, how much?
Have you ever had eye trauma? YES____ NO____ Right/Left Eye If YES, please explain _____

Do any medical or eye diseases run in your family (cancer, glaucoma, macular degeneration, high blood pressure, diabetes)
YES____NO____ If YES, please explain _____
Are you being treated for any other condition now? YES____NO____ If YES, please explain _____
Reason for visit _____

Doctor Signature _____ DATE

PATIENT LIABILITY FORM

Due to the many changes in insurance coverage and regulations, we are asking you to be aware of specific benefit limitations that may be applicable to your policy. It is **YOUR RESPONSIBILITY** to be aware of your insurance benefits, deductibles, co-pays, or cost-sharing.

It is also your responsibility to know whether or not you need a referral and to request and provide such upon each visit. Without a referral you will be made responsible for all charges incurred at time of service.

Please be sure to provide us with your current insurance information, this will avoid confusion and collection complications and will help us serve you more effectively.

Your cooperation in this matter is greatly appreciated.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

_____

ACCOUNT #

Michigan Glaucoma Specialist, P.C.

Dear Patient:

For your convenience and safety, we are introducing a computerized prescription program that will improve both the accuracy and convenience of prescribing medications. This program will allow for the electronic transmission of most of your prescriptions directly to your pharmacy of choice and will eliminate your waiting time. In most cases, it will also accommodate the transmissions of your prescription to mail order pharmacies.

To implement this new program, we need to collect some information from you on your pharmacies of choice. We will define one pharmacy as your main pharmacy; however, you may also provide the information for additional pharmacies to be used as an alternative. In addition, if you have a mail order benefit program, please provide that information by selecting the appropriate box below.

We understand that you may not have the complete pharmacy information with you today. Please provide any information possible regarding the location (street, city, phone, fax) as any information provided will be helpful.

PATIENT NAME: _____ Date of Birth: _____

MAIN PHARMACY:

Name (i.e. CVS, Rite-Aid, etc): _____
Street Name & City: _____
Phone: _____ Fax: _____

ADDITIONAL PHARMACIES YOU WOULD LIKE KEPT ON FILE:

Name (i.e. CVS, Rite-Aid, etc): _____
Street Name & City: _____
Phone: _____ Fax: _____

Name (i.e. CVS, Rite-Aid, etc): _____
Street Name & City: _____
Phone: _____ Fax: _____

MAIL ORDER:

☐ Medco

☐ CareMark/ Pharmacare

☐ Express Scripts, Inc.

☐ Other _____

Please list your drug allergies:

_____
_____
_____