MICHIGAN GLAUCOMA SPECIALISTS, P.C. - PATIENT INFORMATION

Name:_____ Date of Birth:_____

Address:_____ Gender: M / F / OTHER:_____(circle one)

City:_____ State:_____ Zip:_____

Primary Phone #:_____ Home / Cell / Work (circle one)

Alternate Phone #:_____ Home / Cell / Work (circle one)

Occupation:_____ Marital Status: S M W D (circle one)

E-Mail (for patient portal):_____

Employed? YES / NO (circle one) Employer:_____

NAME OF INSURANCE(S):_____

POLICY NUMBER ï 1st Insurance_____ / GROUP #_____

POLICY NUMBER ï 2nd Insurance_____ / GROUP #_____
Who is the insurance through? SELF / SPOUSE / OTHER_____ (circle one)
If other than self, name of Subscriber:_____
Relationship:_____ Date of Birth:_____ SSN:_____
Employer of Subscriber:_____
Employer Address:_____

Pharmacy Name: _____Phone #_____

Pharmacy Address:_____Phone #_____

Referring Physician:_____

Referring Physician Address:_____Phone #_____

Primary Care Physician:_____

Primary Care Physician Address:_____Phone #_____

DISCLOSURE OF INFORMATION CONTACTS

If you anticipate you will need or want your medical information to be provided to family members, friends, or caregivers, please indicate below so that we may best serve you. By signing below, you authorize the following persons to receive information, as requested, regarding your care and treatment.

Name:_____ Phone # _____

Relationship to You:_____

Name:_____ Phone # _____

Relationship to You:_____

PATIENT OR GUARDIAN SIGNATURE:_____ DATE:_____

MICHIGAN GLAUCOMA SPECIALISTS, PC
MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ **Date of Birth:** ____/____/_____ **Sex: M / F**

Primary Care Physician: _____ **Referring Physician:** _____

Pharmacy: _____ **Location** (street & city): _____

Ethnicity:	**Race:**	**Preferred Language:**	
☐ Hispanic ☐ Not Hispanic	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White	☐ English ☐ French ☐ Polish ☐ Spanish ☐ Other: _____	**CURRENT HEIGHT:** _____ **CURRENT WEIGHT:** _____ **IF DIABETIC: [TYPE 1] OR [TYPE 2] ?** **Last Blood Sugar Level:** _____ **Last Hemoglobin A1C:** _____

Allergies	**Reaction**
_____	rash/ shortness of breath/ GI upset/ other
_____	rash/ shortness of breath/ GI upset/ other
_____	rash/ shortness of breath/ GI upset/ other
_____	rash/ shortness of breath/ GI upset/ other

Past Ocular History: (Please mark all that apply)

☐ Amblyopia	☐ Diabetic Retinopathy	☐ Iritis	☐ Optic Neuritis
☐ Aphakia	☐ Dry Eyes	☐ Keratoconus	☐ Retinal Detachment
☐ Astigmatism	☐ Glaucoma	☐ Macular Degeneration	
☐ Cataracts	☐ Hyperopia (Far Sighted)	☐ Myopia (Near Sighted)	☐ Other: _____

Ocular Surgeries: (Please mark all that apply)

☐ Blepharoplasty	☐ LASIK	☐ RK	☐ Vitrectomy
☐ Cataract Surgery	☐ PRK (eye muscle surgery)	☐ Strabismus Surgery	☐ None
☐ Corneal Transplant	☐ Punctal Plugs	☐ Trabeculectomy (glaucoma surgery)	
☐ Foreign Body Removal	☐ Retinal Laser Surgery		☐ Other: _____

Current Eye Medications: (Please list)

_____ _____

_____ _____

_____ _____

_____ _____

Other Medical History : (Please mark all that apply)

☐ Anemia	☐ Congestive Heart Failure	☐ High Blood Pressure	☐ Meningitis
☐ Arthritis	☐ COPD	☐ High Cholesterol	☐ Migraine
☐ Arrhythmia	☐ Diabetes Type 1	☐ Histoplasmosis	☐ MRSA
☐ Asthma	☐ Diabetes Type 2	☐ HIV / AIDS	☐ Polymyalgia
☐ Bleeding Disorder	☐ Eczema	☐ Kidney Disease	☐ Psychiatric Disorder
☐ Cancer	☐ Fibromyalgia	☐ Kidney Stones	☐ Skin Cancer
☐ Chicken Pox	☐ Headache	☐ Liver Disease	☐ Stroke
☐ Hepatitis A / B / C	☐ Hearing Loss	☐ Lung Disease	☐ Thyroid Disease
☐ Herpes Simplex	☐ Herpes Zoster / Shingles	☐ Lupus	☐ Syphillis

General Surgeries / Operations: (Please list)

_____ _____
_____ _____
_____ _____
_____ _____

Current Systemic Medications: (Please list)

_____ _____
_____ _____
_____ _____
_____ _____

Family History: (Please mark all that apply)

☐ Arthritis	☐ Glaucoma	☐ Macular Degeneration
☐ Blindness	☐ Heart Disease	☐ Retinal Disease
☐ Cancer	☐ High Blood Pressure	☐ Stroke
☐ Cataracts	☐ Kidney Disease	☐ TB
☐ Diabetes	☐ Lazy Eye	

Social History:	**Alcohol Use:**	**Drug Use:**
☐ Current Everyday Smoker	☐ Yes	☐ Yes
☐ Current Some Day Smoker	☐ No	☐ No
☐ Former Smoker		
☐ Never Smoked	If yes, how much/often? _____	If yes, how much/often? _____

Review of Systems: (Please mark all that apply)

Eyes
- ☐ Previous Surgery
- ☐ Contact Lens
- ☐ Pain
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Dry Eyes
- ☐ Flashes
- ☐ Floaters

Ear, Nose, and Throat
- ☐ Hard of Hearing
- ☐ Ringing in Ears
- ☐ Vertigo

Cardiovascular
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Shortness of Breath
- ☐ Irregular Heart Beat
- ☐ Difficulty Lying Flat

Constitutional
- ☐ Fatigue/Weakness
- ☐ Fever
- ☐ Weight Gain / Loss

Respiratory
- ☐ Cough
- ☐ Congestion
- ☐ Wheezing
- ☐ Asthma

Gastrointestinal
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Jaundice
- ☐ Hepatitis

Genito-Urinary
- ☐ Pain / Difficulty
- ☐ Blood in Urine
- ☐ History of Kidney Stones
- ☐ History of STD's

Psychiatric
- ☐ Anxiety / Depression
- ☐ Mood Swings
- ☐ Difficulty Sleeping

Endocrine
- ☐ Increased Thirst
- ☐ Increased Hunger
- ☐ Increased Urination
- ☐ Increased Sweating
- ☐ Fingernail Changes

Blood / Lymphnodes
- ☐ Easy Bruising
- ☐ Gums Bleed Easy
- ☐ Prolonged Bleeding
- ☐ Heavy Aspirin Use

MusculoSkeletal
- ☐ Stiffness
- ☐ Arthritis
- ☐ Joint Pain / Swelling

Skin
- ☐ Rash / Sores
- ☐ Lesions
- ☐ Hives
- ☐ Eczema

Neurological
- ☐ Seizures
- ☐ Weakness / Paralysis
- ☐ Numbness
- ☐ Tremors

Immunologic
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Michigan Glaucoma Specialists, P.C.

Richard L. Watnick, M.D. • Tom Obertynski, M.D. • Stephen P. Walters, M.D.

PATIENT ACKNOWLEDGEMENTS

Agreement of Responsibility

I understand that professional services, diagnostic tests and other medical services rendered to me are my financial responsibility or that of the patient's guarantor (the responsible party in the case of minors). I understand that I am financially responsible for all charges not covered by my insurance company. Also I understand I am responsible to fully understand how my insurance operates and if need be I will obtain a referral from my insurance company for my services. ***Otherwise the non-covered charges will be my responsibility***.

Eyeglass Prescription (Refraction):

I understand that a refraction is a service that is not covered by Medicare or most health insurance carriers. If my doctor provides a refraction with an eyeglass prescription, I understand I will be responsible for this charge, which is payable at the time of service. ***THE COST FOR THIS CHARGE IS $40.00***

Consent to Treat

I consent to care / treatment as prescribed by my physician as necessary in their judgement.

Release of Information / Assignment of Benefits

I authorize all my insurance submissions along with the release of my information needed to process my claim to my eligible insurance(s) for payment. I authorize payment to be issued directly to my provider for services rendered. **I also understand that I WILL** receive a monthly statement for any balance due to me.

HIPAA Compliance Patient Consent

Our notice of privacy practices provides information about how we may use or disclose your protected health information. Protected health information may be disclosed or used for treatment, payment or healthcare treatment by our practice or another provider to which you may be referred for additional care.

By signing this form I have read and understand all the statements above:

Patient Name:_____

Patient (Guarantor) Signature:_____

MICHIGAN GLAUCOMA AND CATARACT
LIFESTYLE QUESTIONS

Understanding your lifestyle and the activities you enjoy can help us recommend the kind of cataract surgery that will provide you with clearer vision and less dependence on glasses

Name_____

What is (or was) your occupation?_____

Please circle the following activities you do on a regular basis:

Distance Vision:

Driving - Daytime

Driving - Nighttime

Golfing/other sports

Watching movies/going to the theater

Viewing scenery/taking photographs

Other:_____

Intermediate Vision:

Seeing car dashboard

Using the computer

Using a tablet

Shopping

Playing cards

Other:_____

Near Vision:

Reading books/newspapers

Doing crossword puzzles

Using a cell phone

Sewing/Needlepoint

Applying Makeup

Other:_____

Are you having any difficulty with the following with your current vision

Bright daylight Nighttime street lights/headlights Reading

Please circle on the continuum, 1 being least important 10 being most where it best describes how you feel about the following:

Correction of near vision
(e.g. reading, use of phone) **1 2 3 4 5 6 7 8 9 10**

Correction of intermediate vision:
(e.g. using a tablet/computer) **1 2 3 4 5 6 7 8 9 10**

Correction of distance vision
(e.g. driving, watching television) **1 2 3 4 5 6 7 8 9 10**

Your doctor will discuss the advantages and disadvantages of the various options for cataract surgery. Please indicate how knowledgeable you are about your cataract surgery options

Not Knowledgeable Somewhat knowledgeable Knowledgeable

Which of the following best describes your personality type?

Easygoing Flexible Organized/Planner Perfectionist