CENTER ROAD EYE INSTITUTE

3364 South Center Road, Burton, MI 48519

(810) 743-3937 ~ (810) 743-9210 fax

Welcome to or back to our office and thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

Last Name _____

First Name _____ **Middle Initial** _____ **Suffix** _____

Salutation - Dr. Miss Mr. Mrs. Ms.

Preferred Name _____ **Address** _____

Date of Birth _____ _____ _____ _____

City State Zip

Social Security Number _____ _____ _____

Home Phone Number **Day Phone Number**

Communication preference – **Phone or Email** **Email** -_____ ○**Permission to send emails?**

(Please circle your preference) ○ **Would you like to receive a copy of your exam or patient education forms?**

(Please circle) Government is requiring that we ask the following questions. If you choose not to answer please check "I do not want to specify" Thank You.

Ethnicity – Hispanic or Latino / Not Hispanic or Latino / Unknown

Race – Black or African American / White / Caucasian / Native American / American Indian or Alaskan Native / Asian / Native Hawaiian or other Pacific Islander / Other _____ ___ I do not want to specify

Preferred Language __English/Other_____

Gender ○ Male ○ Female **Blood Pressure _____/_____** **Height - _____ Weight _____**

Guardian/Representative _____ **Emergency Contact**_____

Employer _____ **School** _____ _____

Emergency Contact Phone Number

Primary Care Physician _____ **PCP phone number** _____

Pharmacy _____ Phone number_____

Who referred you here today?_____

INSURANCE

PRIMARY INSURANCE

_____

Name of Insurance

_____ _____ _____

Insured's Identification Number Group Number Insured's Name & Date of Birth

SECONDARY INSURANCE

_____

Name of Insurance

_____ _____ _____

Insured's Identification Number Group Number Insured's Date of Birth

_____ _____ _____

Third Insurance Name Contract Number Insured's Name

_____ _____ _____

Fourth Insurance Name Contract Number Insured's Name

X_____ **Date _____**

→Signature/ Signature of Guardian

CENTER ROAD EYE INSTITUTE

3364 South Center Road, Burton, MI 48519

(810) 743-3937 ~ (810) 743-9210 fax

Past Surgeries –

Major Illnesses –

Allergy History –

Current Medication & dosages –

Has your Primary Care Doctor told you that you have any of the following diseases?

EYE DISEASES

- ◯ Yes ◯ No Amblyopia
- ◯ Yes ◯ No Blepharitis
- ◯ Yes ◯ No Blindness
- ◯ Yes ◯ No Cataract(s)
- ◯ Yes ◯ No Color Blindness
- ◯ Yes ◯ No Diabetic Retinopathy
- ◯ Yes ◯ No Dry Eye Syndrome
- ◯ Yes ◯ No Eye Injuries
- ◯ Yes ◯ No Glaucoma
- ◯ Yes ◯ No Glaucoma Suspect
- ◯ Yes ◯ No High Risk Medication
- ◯ Yes ◯ No Macular Degeneration
- ◯ Yes ◯ No PVD
- ◯ Yes ◯ No Retinal Detachment
- ◯ Yes ◯ No Strabismus
- ◯ Yes ◯ No Other _____

CURRENT EYE SYMPTOMS

- ◯ Yes ◯ No Glare
- ◯ Yes ◯ No Headaches
- ◯ Yes ◯ No Light Sensitivity
- ◯ Yes ◯ No Tired Eyes
- ◯ Yes ◯ No Burning
- ◯ Yes ◯ No Dryness
- ◯ Yes ◯ No Epiphora
- ◯ Yes ◯ No Eyelid Swelling
- ◯ Yes ◯ No Eye Pain or soreness
- ◯ Yes ◯ No Foreign Body
- ◯ Yes ◯ No Infection of Eye Lid
- ◯ Yes ◯ No Itching
- ◯ Yes ◯ No Mucous
- ◯ Yes ◯ No Ptosis (Drooping Eyelids)
- ◯ Yes ◯ No Redness
- ◯ Yes ◯ No Sandy or Gritty Feeling
- ◯ Yes ◯ No Blurred Vision Distance
- ◯ Yes ◯ No Blurred Vision Near
- ◯ Yes ◯ No Distorted Vision
- ◯ Yes ◯ No Flashes of lights
- ◯ Yes ◯ No Floaters or Spots
- ◯ Yes ◯ No Fluctuating Vision
- ◯ Yes ◯ No Loss of Central Vision
- ◯ Yes ◯ No Loss of Side Vision
- ◯ Yes ◯ No Loss of Vision
- ◯ Yes ◯ No Other _____

Check any diseases that someone in your immediate family has been diagnosis with

FAMILY HISTORY

Relationship

- ◯ Yes ◯ No Amblyopia _____
- ◯ Yes ◯ No Blindness_____
- ◯ Yes ◯ No Cataracts _____
- ◯ Yes ◯ No Color Blindness_____
- ◯ Yes ◯ No Eye Tumors _____
- ◯ Yes ◯ No Glaucoma_____
- ◯ Yes ◯ No Glaucoma Suspect_____
- ◯ Yes ◯ No Macular Degeneration_____
- ◯ Yes ◯ No Retinal Detachment_____
- ◯ Yes ◯ No Strabismus _____
- ◯ Yes ◯ No Other Eye Cond._____
- ◯ Yes ◯ No Arthritis_____
- ◯ Yes ◯ No Cancer_____
- ◯ Yes ◯ No Diabetes _____
- ◯ Yes ◯ No Heart Disease _____
- ◯ Yes ◯ No High Blood Pressure_____
- ◯ Yes ◯ No Kidney Disease _____
- ◯ Yes ◯ No Lupus _____
- ◯ Yes ◯ No Stroke _____
- ◯ Yes ◯ No Thyroid Disease _____
- ◯ Yes ◯ No Other Disease _____

CENTER ROAD EYE INSTITUTE

3364 South Center Road, Burton, MI 48519

(810) 743-3937 ~ (810) 743-9210 fax

Have you experienced any of these symptoms?

- ○ Yes ○ No Fever
- ○ Yes ○ No Fatigue
- ○ Yes ○ No Hearing Loss
- ○ Yes ○ No Sinus Disorders

Have you had or currently have any of the following?

- ○ Yes ○ No Atrial Fibrillation
- ○ Yes ○ No Heart Disease
- ○ Yes ○ No Hypertension
- ○ Yes ○ No Stroke/TIA
- ○ Yes ○ No Asthma
- ○ Yes ○ No Emphysema/COPD
- ○ Yes ○ No Shortness of breath
- ○ Yes ○ No Intestinal Conditions
- ○ Yes ○ No Flomax Use
- ○ Yes ○ No Kidney Disease
- ○ Yes ○ No Urinary Conditions/Symptoms
- ○ Yes ○ No Arthritis
- ○ Yes ○ No Muscle/Joint/Back Pain
- ○ Yes ○ No HIV/AIDS
- ○ Yes ○ No TB
- ○ Yes ○ No Herpes
- ○ Yes ○ No Rash/Itching
- ○ Yes ○ No Rosacea
- ○ Yes ○ No Shingles
- ○ Yes ○ No Skin Cancer
- ○ Yes ○ No Multiple Sclerosis
- ○ Yes ○ No Frequent Headaches
- ○ Yes ○ No Convulsions/Seizure
- ○ Yes ○ No Memory Loss
- ○ Yes ○ No Depression
- ○ Yes ○ No Diabetes
  HbA1C _____
- ○ Yes ○ No Thyroid Disease
- ○ Yes ○ No Anemia
- ○ Yes ○ No Cholesterol
- ○ Yes ○ No Seasonal Allergies
- ○ Yes ○ No Lupus
- ○ Yes ○ No Pregnant
- ○ Yes ○ No Nursing
- ○ Yes ○ No Hepatitis
- ○ Yes ○ No Blood Transfusion

Social History –

Current Occupation _____ Years _____ Employer_____

Do you drink alcohol? ○ No ○ Occasional ○ 1 per day ○ 2-3 per day ○ 4+ per day

Do you smoke? ○ No ○ Occasional ○ ½ pack per day ○ 1 pack per day ○ 1+ pack per day

Past smoker ○ Yes ○ No When did you quit smoking? _____

Tobacco use cessation intervention, counseling? ○ Yes ○ No Tobacco cessation pharmacologic therapy? ○ Yes ○ No

Do you chew tobacco? ○ Yes ○ No Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you use illegal drugs? ○ Yes ○ No Do you engage in regular exercise? ○ Yes ○ No

Ethnicity (optional) _____ Marital Status (optional) _____

Do you use a computer? ○ Yes ○ No Hours per day _____ Distance from computer _____

Do you drive? ○ Yes ○ No Daily mileage _____ Do you have visual difficulty when driving? ○ Yes ○ No

Do you have glare problems? ○ Yes ○ No Do you have any problems with night vision? ○ Yes ○ No

Do you currently wear glasses? ○ Yes ○ No Since _____ ○ Full Time ○ Part Time ○ Distance ○ Close

Glasses owned ○ Single Vision ○ Safety glasses ○ Bifocals ○ Sports glasses ○ Trifocals ○ Progressive ○ Back-up glasses ○ Other

Have you had trouble in the past with glasses? ○ Yes ○ No If yes, please explain _____

Do you wear sunglasses? ○ Yes ○ No Are your sunglasses your current prescription ○ Yes ○ No

Special Eyewear Needs

- ○ Computer (special prescriptions, special anti-glare tints or coating)
- ○ Safety glasses (gardening, woodworking, welding)
- ○ Occupational (mechanics, plumbers, pilots)
- ○ Sports/Hobbies (racquet sports, motorcycle)

Hobbies/interests _____

Have you tried to wear contact lenses? ○ Yes ○ No Reason for stopping _____

If not a contact lens wearer, are you interested in trying contact lenses at this time? ○ Yes ○ No

Do you currently wear contact lenses? ○ Yes ○ No Since _____

Type and brand of contact lenses _____

How many hours/day? _____ How many days/week? _____ Today's wearing time? _____

What contact lens solution do you use? Cleaner _____ Disinfectant_____

Please rate the following on a scale of 1-10, with 1 being POOR and 10 being EXCELLENT

Lens comfort _____ Right _____ Left Distance Vision _____Right _____ Left Near Vision _____ Right _____Left

CENTER ROAD EYE INSTITUTE

3364 South Center Road, Burton, MI 48519

(810) 743-3937 ~ (810) 743-9210 fax

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible.

IT IS YOUR REPSONSIBILITY TO KNOW YOUR INDIVIDUAL COVERAGE.

This includes what procedures are covered, eligibility, waiting periods and deductibles.

Failing to comply could result in you being responsible for all costs incurred. Please remember, your insurance policy is between you are your insurance company- and not with the insurance company and your doctor.

I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

_____

→Patient / Legal Guardian's *Signature* **Date**

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)

I, THE UNDERSIGNED, HAVE READ AND ACKNOWLEDGE THE Notice of Privacy Practices.

_____

Print Full Name, Parent or Personal Representative **Date**

_____

→*Signature* of Patient, Parent or Personal Representative **Date**

_____

Personal Representative's relationship to the patient.

OFFICE NO SHOW POLICY-

AFTER 3 NO SHOW APPOINTMENTS WE WILL NO LONGER BE ABLE TO SEE YOU AS A PATIENT.

Initials of the patient _____

I HEREBY AUTHORIZE AND REQUEST THE DOCTORS WITH CENTER ROAD EYE INSTITUTE TO RELEASE INFORMATION TO THE FOLLOWING PEOPLE/PHYSICIAN

_____

_____

→*Signature* of the patient

IF THE PATIENT IS A MINOR, FILL IN THE FOLLOWING INFORMATION		
If the parents are divorced, who is the custodial parent?_____ □ MOTHER □ FATHER □ BOTH		
I hereby authorize and request the doctors with Center Road Eye Institute to examine diagnose and treat the person listed above for whom I am legally authorized to give consent.		
Patient Name		
Parent/Legal Guardian ***Signature***	Relationship to Patient	Date
Parent/Legal Guardian Name (print)	Parent/Legal Guardian's Birth Date	
Parent/Legal Guardian's Social Security Number		

CENTER ROAD EYE INSTITUTE

3364 South Center Road, Burton, MI 48519

(810) 743-3937 ~ (810) 743-9210 fax

CONSENT OF MEDICAL BILLING

Dear Patient,

This is a specialist office and the Doctor will perform a complete comprehensive dilated medical examination and will document any medical diagnoses that they find.

Therefore, our office cannot bill your vision insurance for your examination today. Also, the office cannot bill medical and vision insurances for the same office visit. If glasses or contacts are needed the office will bill your routine vision insurance (if eligible) for that purchase.

** If you have not met your medical deductible for the year you will be responsible for your deductible/copay determined by your health insurance plan. If you have any questions or concerns about your cost please contact your medical insurance directly. **

**If you would like to know what your medical diagnosis is or have any questions about your medical diagnosis please ask our physicians before the end of your examination. You can also request a copy of your examination at checkout. **

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions. I confirm that I am the patient, or the patient's authorized representative/guardian.

Patient or Representative Signature _____ Date _____

If signed by someone other than the patient, please specify the relationship to the patient:

_____