Registration : **Glaucoma Center Of Michigan**

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Address	Home: / Work: / Cell: / Email:	How did you hear of us?
Address 2		

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Pharmacy Phone

Provider **Family Physician** **Referring Physician**

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

Do you want to receive your statements via Email? 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	
X		29201 Telegraph Rd., Suite 301	Phone: 248-356-0098
		Southfield, MI 48034	Email:

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.

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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:

_____Date:_____
Signature - Patient or Responsible Party

_____Date:_____
Signature - Co-Responsible Party

By signing this document, I agree, in order for Glaucoma Center of Michigan, P.C. to service my account or to collect any amounts I may owe, Glaucoma Center of Michigan P.C. and its third party billing and/or debt collection service providers may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which may result in charges to me. Additionally, I authorize contact via text messages or e-mails, using any e-mail address I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, if applicable.

I/We have read this disclosure and authorize express consent that Glaucoma Center of Michigan P.C., its affiliates and third party service providers may contact me/us as described above.

_____Date:_____
Signature - Patient or Responsible Party

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?_____

CATARACT SURGERY? ____YES____NO WHEN?_____

GLAUCOMA SURGERY?____YES____NO WHEN?_____

HAVE YOU HAD ANY LASER TREATMENTS ON YOUR EYES?____YES____NO WHEN?_____

IS THERE ANY FAMILY HISTORY OF GLAUCOMA?
____YES____NO IF YES WHO?_____

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

ARE YOU ALLERGIC TO ANY MEDICATIONS?____YES____NO
WHICH DRUGS?_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

DIABETES
____YES ____NO HOW LONG?_____

HIGH BLOOD PRESSURE
____YES ____NO HOW LONG?_____

KIDNEY STONES
____YES ____NO HOW LONG?_____

ANGINA
____YES ____NO WHEN?_____

HEART ATTACK
____YES ____NO WHEN?_____

STROKE
____YES ____NO WHEN?_____

HAVE YOU EVER BEEN IN SHOCK?
____YES ____NO WHEN?_____

HAVE YOU EVER HAD A BLOOD TRANSFUSION?
____YES ____NO WHEN?_____

HAVE YOU EVER USED STERIOD DRUGS?
____YES ____NO (CORTISONE/PREDNISONE)

ASTHMA / EMPHYSEMA
____YES ____NO HOW LONG?_____

MIGRAINE HEADACHES
____YES ____NO HOW LONG?_____

HIV
____YES ____NO HOW LONG?_____

TB ____YES ____NO HOW LONG?_____

HEPATITIS ____YES ____NO HOW LONG?_____

DO YOU SMOKE?____YES ____NO IF YES
Please Circle - Occasional / Regularly _____pack(s) per day

DO YOU DRINK ALCOHOL?____YES ____NO IF YES
Please Circle - Occasional / Regularly _____drink(s) per day

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:**_____

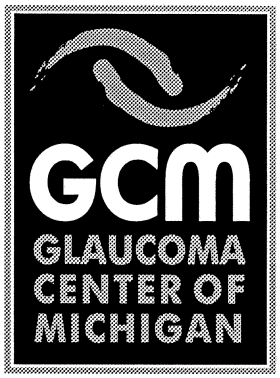
REVIEW OF SYSTEMS: If you are currently having any problems in the following areas, circle and explain (if necessary).

CONSTITUTIONAL SYMPTOMS: (fever, weight loss, chills, sweats) None _____
Explain:_____
EYES: (please see ocular exam) None _____
Explain:_____
ENMT (Ears, Nose, Mouth, Throat): (hearing loss, ringing, infection, bleeding, loss of smell, congestion, dry mouth, loss of taste, difficulty swallowing, hoarseness) None _____
Explain: _____
CARDIOVASCULAR: (chest pain, palpitations, leg edema, increased heart rate, cold hands/feet, shortness of breath) None _____
Explain:_____
RESPIRATORY: (wheezing, cough, difficulty breathing) None _____
Explain:_____
GASTROINTESTINAL: (reflux, diarrhea, nausea, vomiting, indigestion, constipation, change in bowel habits, bleeding, pain/cramps) None _____
Explain:_____
GENITOURINARY (genitals, kidneys, bladder): (urination [bleeding, pain, incontinence, burning, frequency], discharge, ulcer, hesitancy, pain/bleeding, kidney stones, infections) None _____
Explain:_____
INTEGUMENTARY: (rosacea, rash, change in hair texture, change in nails) None _____
Explain:_____
MUSCULOSKELETAL: (gout, arthritis, joint pain, muscle pain, back pain, joint swelling) None _____
Explain:_____
NEUROLOGICAL: (slurred speech, memory loss, gait disturbances, loss of coordination, dizziness, headaches, vertigo) None _____
Explain:_____
HEMATOLOGIC: (abnormal bleeding, enlarged lymph nodes, swollen glands, easily bruised) None _____
Explain:_____
IMMUNOLOGIC: (food allergies, seasonal allergies, immune disorders, recurrent infections, drug sensitivity/allergy) None _____
Explain: _____
ENDOCRINE: (fatigue, fainting, confusion, nervousness, hot/cold intolerance, hair loss, excessive hair growth) None _____
Explain:_____
PSYCHIATRIC: (depression, panic disorder, anxiety, disorientation, mood swings, hallucinations) None _____
Explain:_____
FEMALES: Are you pregnant? Yes / No Nursing? Yes / No N/A _____
BREASTS: (tenderness, swelling, lumps, discharge, other) None _____
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_____



All patients are expected to pay their co-pay for office visits on the day of service.

A fee of $20.00 will be charged if we are required to bill you for the co-pay.

Patient Signature **Date**

Thank You.