PAYMENT IS EXPECTED AT TIME OF SERVICE

PATIENT DATA
PLEASE PRINT

PATIENT'S LEGAL NAME: LAST ____________ FIRST ____________ INITIAL ____________

❑ MALE ❑ FEMALE ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED EMAIL: ____________

HOME PHONE: (_______) ____________ ALTERNATE PHONE: (_______) ____________ CELL: (_______) ____________

SPOUSE'S NAME: ____________ SPOUSE'S WORK PHONE: (_______) ____________

PATIENT'S ADDRESS: ____________ CITY ____________ STATE ________ ZIP ____________

SOCIAL SECURITY NUMBER: ____________ DATE OF BIRTH: ____________ AGE: ____________

EMPLOYED BY: ____________ OCCUPATION: ____________

EMPLOYER ADDRESS: ____________

TYPE OF INSURANCE: ____________

I.D. NUMBER ____________ GROUP: ____________ SERVICE CODE: ____________

OTHER MEDICAL INSURANCE: ____________

MEDICARE NUMBER: ____________

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME: ____________

RELATIONSHIP TO PATIENT: ____________

ADDRESS (if different than patient): ____________

PHONE: ____________

EMPLOYED BY: ____________

EMPLOYER ADDRESS: ____________

WORK PHONE: ____________ OCCUPATION: ____________

TYPE OF INSURANCE: ____________

I.D. NUMBER ____________ GROUP: ____________ SERVICE CODE: ____________

REFERRED BY

HOW DID YOU HEAR ABOUT US: ____________

REFERRED BY DOCTOR: ____________ FRIEND/RELATIVE: ____________

NEWSPAPER AD; ____________ TV AD: ____________ RADIO AD: ____________

ESTABLISHED PATIENT: ____________

OTHER: ____________

IN CASE OF EMERGENCY

NAME OF RELATIVE OR FRIEND AT A DIFFERENT ADDRESS: (In case we cannot reach you.)

NAME: ____________ PHONE: ____________

5813 West Maple Rd., Suite 137 ▪ West Bloomfield, MI 48322 ▪ (248) 855-6200 ▪ FAX (248) 855-7721
8599 W. Grand River ▪ Brighton, MI 48116 ▪ (810) 227-6161

MEDICAL

PLEASE ANSWER ALL MEDICAL QUESTIONS

ARE YOU PRESENTLY EXPERIENCING EYE PROBLEMS? ❑ YES ❑ NO IF YES, PLEASE EXPLAIN ______________________________

____

HAVE YOU EXPERIENCED EYE PROBLEMS IN THE PAST? ❑ YES ❑ NO IF YES, PLEASE EXPLAIN ______________________________

____

HAS ANYONE IN YOUR FAMILY HAD: ❑ CATARACTS ____________ Relationship ❑ GLAUCOMA ____________ Relationship

❑ NONE ❑ DIABETES ____________ Relationship ❑ HYPERTENSION ____________ Relationship

DURING THE PAST YEAR, HAVE YOU BEEN UNDER A PHYSICIAN'S CARE: ❑ YES ❑ NO

IF YES, EXPLAIN: ____

PLEASE ANSWER ALL OF THE FOLLOWING:

SERIOUS ILLNESS ❑ NO ❑ YES *(Describe)* ____

MAJOR OPERATION ❑ NO ❑ YES *(Describe)* ____

HIGH/LOW BLOOD PRESSURE	❑ NO ❑ YES	ARTHRITIS	❑ NO ❑ YES	KIDNEY/BLADDER TROUBLE	❑ NO ❑ YES
BLEEDING PROBLEMS	❑ NO ❑ YES	ULCERS	❑ NO ❑ YES	SINUS TROUBLE	❑ NO ❑ YES
HEART DISEASE	❑ NO ❑ YES	PACEMAKER	❑ NO ❑ YES	X-RAY THERAPY	❑ NO ❑ YES
HEPATITIS/ LIVER TROUBLE	❑ NO ❑ YES	STROKE	❑ NO ❑ YES	HEADACHE FREQUENT/SEVERE	❑ NO ❑ YES
PSYCHIATRIC TREATMENT	❑ NO ❑ YES	DIABETES	❑ NO ❑ YES	THYROID	❑ NO ❑ YES
CORTISONE, HYDROCORTISONE	❑ NO ❑ YES	HERPES/SHINGLES	❑ NO ❑ YES	HIV POSITIVE/AIDS	❑ NO ❑ YES
ASTHMA	❑ NO ❑ YES				
ARE YOU PREGNANT?	❑ NO ❑ YES	____________ OTHER	____________		

LIST ALL EYE DROPS CURRENTLY USING: ____

LIST ALL MEDICATIONS, PILLS CURRENTLY USING: ______________________________________

____

____

LIST ALLERGIES: ❑ NONE ❑ PENICILLIN ❑ ASPIRIN ❑ CODEINE ❑ SULFA ❑ OTHER ____________________

WHEN WAS THE LAST TIME YOU RECEIVED A NEW PRESCRIPTION FOR YOUR GLASSES?:____________________

I UNDERSTAND AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT. I CERTIFY THIS INFORMATIONS IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. ALL UNPAID BALANCES WILL BE CHARGED INTEREST AT 1 1/2% PER MONTH AFTER 30 DAYS.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND AUTHORIZE YOU TO BILL MY INSURANCE.

PATIENT SIGNATURE: ____
(OR PARENT OR GUARDIAN'S SIGNATURE IF PATIENT IS A MINOR)

DATE: ____