

# Greenberg Laser Eye Center Patient Update Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status:  S  M  D  W

Name Change:  Y  N

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Preferred

Preferred

Email: \_\_\_\_\_

\*\*\*We do not share or sell your email information, it is only used to communicate with you if we are unable to reach you by phone, or if you request to be contacted through email\*\*\*

\*Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\*Emergency Contact Phone: \_\_\_\_\_ (Cannot be the same as above numbers)

\*I authorize Greenberg Laser Eye Center to release my records and any information to the above individual  
 YES  NO

Family Doctor: \_\_\_\_\_ City: \_\_\_\_\_  
First Last

Rheumatologist: \_\_\_\_\_ City: \_\_\_\_\_

Endocrinologist: \_\_\_\_\_ City: \_\_\_\_\_

Neurologist: \_\_\_\_\_ City: \_\_\_\_\_

Cardiologist: \_\_\_\_\_ City: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

## Medical Insurance

Insurance Name: \_\_\_\_\_ Policy ID: \_\_\_\_\_

Primary Subscriber Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

## Vision Insurance

Insurance Name: \_\_\_\_\_ Policy ID: \_\_\_\_\_

Primary Subscriber Name: \_\_\_\_\_ Last 4 digits of SS: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## MEDICAL HISTORY

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Allergies: Reaction Severity**

- Sulfa      mild/moderate/severe
- Penicillin    mild/moderate/severe
- Aspirin      mild/moderate/severe
- Codeine      mild/moderate/severe
- Cipro        mild/moderate/severe
- \_\_\_\_\_ mild/moderate/severe
- \_\_\_\_\_ mild / moderate / severe
- \_\_\_\_\_ mild / moderate / severe

**Current Eye Medications: (Please list)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**All Medications (other than eye): (Please list) + directions/dosage (mg)**

\_\_\_\_\_  
 \_\_\_\_\_

**Vaccines last 12 months:    Flu?    Yes    No      Pneumonia?    Yes    No**

**Have you been on a medication for a prostate condition?    Yes    No**

**Systemic Illnesses / Infections/ Medical Diagnoses:**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> No history of illnesses  | <input type="checkbox"/> Eczema                        | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Rheumatoid Arthritis                 |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Fibromyalgia                  | <input type="checkbox"/> Kidney Stones         | <input type="checkbox"/> Sjogren's                            |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Headache                      | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Stroke                               |
| <input type="checkbox"/> Arrhythmia               | <input type="checkbox"/> Hepatitis A / B / C           | <input type="checkbox"/> Lupus                 | <input type="checkbox"/> Syphilis                             |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Herpes (including cold sores) | <input type="checkbox"/> Meningitis            | <input type="checkbox"/> Thyroid Disease circle: Hypo / Hyper |
| <input type="checkbox"/> Bleeding Disorder        | <input type="checkbox"/> High Blood Pressure           | <input type="checkbox"/> Migraine              | <input type="checkbox"/> Toxoplasmosis                        |
| <input type="checkbox"/> Cancer _____             | <input type="checkbox"/> High Cholesterol              | <input type="checkbox"/> MRSA                  | <input type="checkbox"/> Wound Infection                      |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Histoplasmosis                | <input type="checkbox"/> Multiple Sclerosis    |   |
| <input type="checkbox"/> COPD                     | <input type="checkbox"/> Herpes Zoster (shingles)      | <input type="checkbox"/> Polymyalgia           |   |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> HIV / AIDS                    | <input type="checkbox"/> Psychiatric Disorders |   |

Other \_\_\_\_\_

**Past Eye History: (Please mark all that apply)**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Overall Healthy  | <input type="checkbox"/> Contact Lens Intolerance | <input type="checkbox"/> Glaucoma                     | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Aphakia          | <input type="checkbox"/> Corneal Infection        | <input type="checkbox"/> Hyperopia (Far sighted)      | <input type="checkbox"/> Myopia (Nearsighted) |
| <input type="checkbox"/> Cataracts        | <input type="checkbox"/> Diabetic Retinopathy     | <input type="checkbox"/> Iritis                       | <input type="checkbox"/> Optic Neuritis       |
| <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Dry Eyes                 | <input type="checkbox"/> Keratoconus                  | <input type="checkbox"/> Retinal Detachment   |
|   |   | <input type="checkbox"/> Lazy eye – patched / surgery | <input type="checkbox"/> Trauma               |

Other \_\_\_\_\_

**General Surgeries / Operations: (Please list)**

**Eye and Eyelid Surgeries (including cosmetic procedures):**

No prior eye surgery

Please list all eye surgeries including cosmetic procedures with dates \_\_\_\_\_

**Family History:**

Blindness                       Glaucoma relation? \_\_\_\_\_ living or deceased                       Macular Degeneration  
 Cataracts under 50 years old                       Lazy Eye                       Retinal Detachment

Other \_\_\_\_\_

**Social History: (Please mark all that apply)**

Smoking:     current every day smoker                       current some day smoker                       former smoker                       never smoked

Alcohol Use:                       Yes                       No                      If yes how much and how often? \_\_\_\_\_

Drug Use:                       Yes                       No                      If yes what and how often? \_\_\_\_\_

**Review of Systems: (Please mark all that apply)**

**Eyes**

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

**Respiratory**

- Cough
- Congestion
- Wheezing
- Asthma

**Blood / Lymphnodes**

- Easy Bruising
- Gums Bleed Easy
- Prolonged Bleeding
- Heavy Aspirin Use

**Gastrointestinal**

- Heartburn
- Nausea / Vomiting
- Jaundice / Hepatitis

**MusculoSkeletal**

- Stiffness
- Arthritis
- Joint Pain / Swelling

**Ear, Nose, and Throat**

- Hard of Hearing
- Ringing in Ears
- Vertigo

**Genito-Urinary**

- Pain / Difficulty
- Blood in Urine
- History of Kidney **Stones**
- History of STD's

**Skin**

- Rash / Sores
- Lesions
- Hives / Eczema

**Cardiovascular**

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

**Psychiatric**

- Anxiety / Depression
- Mood Swings
- Difficulty Sleeping

**Neurological**

- Seizures
- Weakness / Paralysis
- Numbness
- Tremors

**Constitutional**

- Fatigue / Weakness
- Fever
- Weight Gain / Loss

**Endocrine**

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

**Immunologic**

- Hives
- Itching
- Runny Nose
- Sinus Pressure

## FINANCIAL POLICY AND BILLING PROCESS GREENBERG LASER EYE CENTER

- **Copay, Co-insurance and Deductibles:** It is my responsibility to know what my copay, co-insurance and deductibles are, and my obligation to pay this at the time of service. If I am not able to pay my co-pay, deductible or coinsurance portion at the time of service my appointment may be rescheduled or subject to a \$15.00 fee. If I receive 3 statements or more, there will be a statement fee of \$20.00 added to my account for each additional statement received.
- **No Show Appointments:** All appointments that are not canceled within 48 business hours of the appointment time are subject to a \$39.00 fee. This \$39.00 fee must be paid before we can reschedule your appointment.
- **Refractions:** Refraction is the process of determining if there is a need for corrective eyeglasses. It is an essential part of an eye examination and necessary in order to write a prescription for glasses or contact lenses. Medicare and most medical insurances do not cover this service. I understand that I am responsible for this \$36.00 fee due at the time of service.
- **Contact lens fitting:** There is a \$120.00 contact lens fitting fee charge for first time wearers and a \$65.00 charge for an established wearer.
- **Insurance Coverage:** I acknowledge that the insurance cards I have presented are current and accurate. If we have not received payment after 90 days, our office reserves the right to send the entire bill to the patient for payment. It will be your responsibility at that point to contact your insurance company with any questions or concerns regarding your bill.
- **Medical vs Vision:** Your **medical insurance** is billed if a medical condition is discovered during your examination.
  - Evaluation of an ocular disease you have been diagnosed with (e.g., glaucoma, cataract, corneal, or retinal disease). A complaint such as redness, tearing, burning, or other pain or discomfort to the eyes.
  - A history of or new onset of floaters, flashes of light, or other visual disturbance.
  - To follow an existing chronic condition such as diabetes, corneal disease, dry eye syndrome, blepharitis and autoimmune disease, or if you take high risk medications like Plaquenil.
  - If you are scheduled for additional testing such as visual field, OCT, or retinal photography.
  - If your visit requires a report to your primary care physician.
- **Participating Insurance Plans:** If GLEC is not a participating provider in my insurance plan, I will be responsible for filing my own claims and I will be responsible for paying in full at the time of service.
- **Non-covered Services:** I understand that some services may be considered non-covered services by my insurance plan. I understand that it is my responsibility to know what my insurance does or does not cover and I understand that I am financially responsible for paying all non-covered services.
- **Denied Charges:** I understand that some charges may be denied by my insurance carrier as investigational, experimental or not medically necessary and will not be paid by my insurance carrier. I understand that my physician feels these services are needed whether my insurance carrier deems them payable or not and that I am obligated to pay for these services in full.
- **Returned Checks & Past Due Accounts:** Returned checks will be subject to collection charges of an additional \$25.00 with penalties and interest. All accounts are considered past due if not paid within 90 days of service. Past due accounts may result in collection turnover and be subject to penalties and interest, or the refusal of future appointments until old balances have been paid in full. The practice does not accept post dated checks.
- **Surgery Charges:** The practice will make every effort to determine your insurance benefits and to relay to you what you will owe for surgery charges, please keep in mind that this is just an estimate. Please be aware that when surgery is performed, you may incur additional charges (in addition to the surgeon's fees) from the surgery facility, anesthesiologist, laboratory or radiologist.

X \_\_\_\_\_

Patient/Representative Signature

Date

Printed Name \_\_\_\_\_

# AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

**Greenberg Laser Eye Center**

**3001 West Big Beaver, Suite 105**

**Troy, MI 48084**

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below.

Name of Patient: \_\_\_\_\_

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general medical information, surgical and billing)?

Yes     No    If yes, please provide:

**Name:** \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Alternate Number: \_\_\_\_\_

**Is this person your Power of Attorney for medical purposes?**     Yes     No

**Name:** \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Alternate Number: \_\_\_\_\_

I hereby authorize the above person to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed the Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_