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:_____

Greenberg Laser Eye Center
3001 W. Big Beaver, Ste. 105, Troy, MI 48084
(248) 649-2820 fax (248) 649-1444 www.greenbergeye.com vision@greenbergeye.com

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:

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

Other_____

Past Eye History: (Please mark all that apply)

☐Overall Healthy
☐Aphakia
☐Cataracts
☐Cataract Surgery
☐Contact Lens Intolerance
☐Corneal Infection
☐Diabetic Retinopathy
☐Dry Eyes
☐Glaucoma
☐Hyperopia (Far sighted)
☐Iritis
☐Keratoconus
☐Lazy eye – patched / surgery
☐Macular Degeneration
☐Myopia (Nearsighted)
☐Optic Neuritis
☐Retinal Detachment
☐Trauma

Other_____

Please continue on the back side of this page →

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
☐ Cataracts under 50 years old
☐ Glaucoma relation?_____living or deceased
☐ Lazy Eye
☐ Macular Degeneration
☐ 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

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

FINANCIAL POLICY AND BILLING PROCESS
GREENBERG LASER EYE CENTER

- **Copay, Co-insurance, Deductibles and Fees:** 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 and/or subject to a **$25.00 fee**. If I receive 3 statements or more, there will be a **$35.00 statement fee** added to my account for each additional statement received. This amount of these fees is subject to change
- **$39.00 NO SHOW, LATE CANCEL, LATE RESCHEDULE Appointments: All appointments that are no showed, canceled or rescheduled within 48 business hours of the appointment time are subject to a $39.00 fee. This $39.00 fee must be paid before I can reschedule my 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 $46.00 test 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:** My **medical insurance** is billed if a medical condition is discovered during my 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 I take high-risk medications like Plaquenil.
    - If I am scheduled for additional testing such as visual field, OCT, or retinal photography.
    - If my visit requires a report to my primary care or other physicians.
- **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 postdated checks.
- **Surgery Charges:** GLEC will make every effort to determine my insurance benefits and to relay to me what I will owe for surgery charges, please keep in mind that this is just an estimate. Please be aware that when surgery is performed, I 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 _____ 1/26

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: _____