Michigan Eye Institute

REGISTRATION FORM

Patient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: _____ SS# (last four digits only): ___ ___ ___ ___
(Information captured for insurance eligibility purposes)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

If Patient is a minor, Guarantor Name: _____ Guarantor Contact Phone: _____

Michigan Eye Institute uses text messaging & email as a preferred method of communication.

Pharmacy Name: _____ Address: _____

Referred By: _____

Primary Care Physician: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Member ID#: _____

Policy Holder's Information (If different from above)

Name: _____ Date of Birth: _____ Sex: _____

Relation: _____

The above information is true to the best of my knowledge. I authorize the release of any medical information necessary to my referring doctor and any insurance company.

I understand that I am responsible for any charges not covered by my insurance company.

To provide you the best healthcare service possible, Michigan Eye Institute will download medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

I voluntarily consent to medical care of a routine/emergency nature from the authorized professional staff of Michigan Eye Institute for myself or the above-mentioned minor for whom I am the parent/guardian. I understand that this consent is valid for one (1) year. It is also understood that I may withdraw this consent at any time by contacting any member of the professional staff in writing.

Patient Signature: _____ Date: _____

If Minor, Parent/Guardian Signature: _____ Date: _____

Michigan Eye Institute

PATIENT HISTORY (Please Print)

Name: _____DOB: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE (First time patients only)
Yellow Pages Internet/Website (mieye.com) Drive-By/Walk In Patient Name_____ Insurance Doctor Name_____
MEDICAL CONDITIONS – Past or Present (diabetes, high blood pressure, arthritis, heart attack, etc.)
SURGERIES, INJURIES, HOSPITALIZATIONS (cataract, laser vision, eye injury, concussions, appendix, etc.)
EYE DISEASES (glaucoma, cataract, "lazy eye, retinal detachments, etc.)
MEDICATIONS (dose and times/day) INCLUDE: eye drops, inhalers, vitamins, OTC (over the counter)
ALLERGIES INCLUDE: drug, food, latex, seasonal, etc.

Do you CURRENTLY have any problems in the following areas? If YES, please provide additional information.

	YES	**NO**	**DETAILS**
EYES (poor vision, vision loss, eye pain, double vision, redness, burning, itching, tearing, gritty sensation, dryness, discharge, glare, halos, flashes, floaters, etc.			
GENERAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (tuberculosis-TB, congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN PROBLEMS (acne, warts, growths, rash, etc.)			

Michigan Eye Institute

NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, etc.)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (HIV +, hepatitis, bleeding, high cholesterol, anemia, blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			
REPRODUCTIVE (pregnant, nursing, etc.)			

FAMILY HISTORY (Mother, Father, Sibling, Grandparent)

	YES	**NO**	**If YES, please explain**
Do any eye diseases run in your family? (Blindness, Cataract, Glaucoma, Macular Degeneration, Retinal Detachments, etc.)			
Does any medical disease run in your family? (High Blood Pressure, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Diabetes, etc.)			

SOCIAL HISTORY

Do you Smoke?	YES	NO	If yes, how much?	How Many Years?
Do you drink alcohol?	YES	NO	If yes, how much?	
Do you use a computer?	YES	NO	If yes, hours per day?	
Hobbies/Sports/Visual Needs:				
Occupation	Current	Retired?	Disabled	Student

US GOVERNMENT REPORTING

RACE:	American Indian	Asian	African American	Caucasian	Type Unknown
ETHNICITY:	Hispanic	Non-Hispanic	Type Unknown		
LANGUAGE:	English	Chinese	French	Hebrew	Hindi
	Japanese	Portuguese	Spanish	Yiddish	Type Unknown
I WOULD PREFER NOT TO DISCLOSE THIS INFORMATION					

Michigan Eye Institute

Limited Patient Authorization for Disclosure of Protected Health Information (PHI)

Please Print. Form must be completed every three (3) years.

Name: _____ Gender: _____

DOB:_____ Date:_____

Purpose of request (who will be authorized to receive information) – I authorize the practice to disclose or provide protected health information to the individual(s) listed below.

Who will provide or disclose information: Michigan Eye Institute 4499 Town Center Parkway Flint, MI 48532

Who will be authorized to receive information (list each family member, friend, or other individual to receive PHI):

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Description of information to be disclosed- I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

Entire patient record, or circle only those items of the record to be disclosed:

Office notes and other physician records

financial history report (previous 3 years only)

Lab results, pathology reports

Only send the following:_____

Purpose of disclosure (please record the purpose of the disclosure or circle patient request):

Patient Request

Other (please specify): _____

Expirations or termination of authorization: This authorization will expire at the end of the third calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this at any time. You must notify our privacy manager in writing if you decide to terminate the authorization prior to the normal expiration date. (Please list date of expiration if earlier than end of calendar year):

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. You may revoke an authorization at any time in writing except to the extent that your Healthcare Provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare treatment.

Redisclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Patient Signature:_____ **Date**:_____

Michigan Eye Institute

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

1. Individual refused to sign.
2. Communication barrier prohibited obtaining the acknowledgement.
3. An emergency prevented us from obtaining acknowledgement.
4. Other (please specify)

Michigan Eye Institute

HIPAA Privacy Rule Receipt of Notice of Privacy Practices

Name:_____ Gender:_____

DOB: _____

Age:_____ Date:_____

I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

1. I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement:

2. This Facility reserves the right to change their Notice of Privacy Practices. If the Notice is changed, you may obtain a revised copy by visiting our website at www.mieye.com or upon request.

Patient Signature: _____ **Date**: _____

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1. Individual refused to sign.
2. Communication barrier prohibited obtaining the acknowledgement.
3. An emergency prevented us from obtaining acknowledgement.

Other (please specify