



Les D. Grosinger, M.D., F.A.C.S.
Alan V. Spigelman, M.D., F.A.C.S.
David S. Grey, M.D., F.A.C.S.

Diplomates American Board of Ophthalmology

Dear New Patient:

Welcome to the practice of Grosinger, Spigelman & Grey, MD.

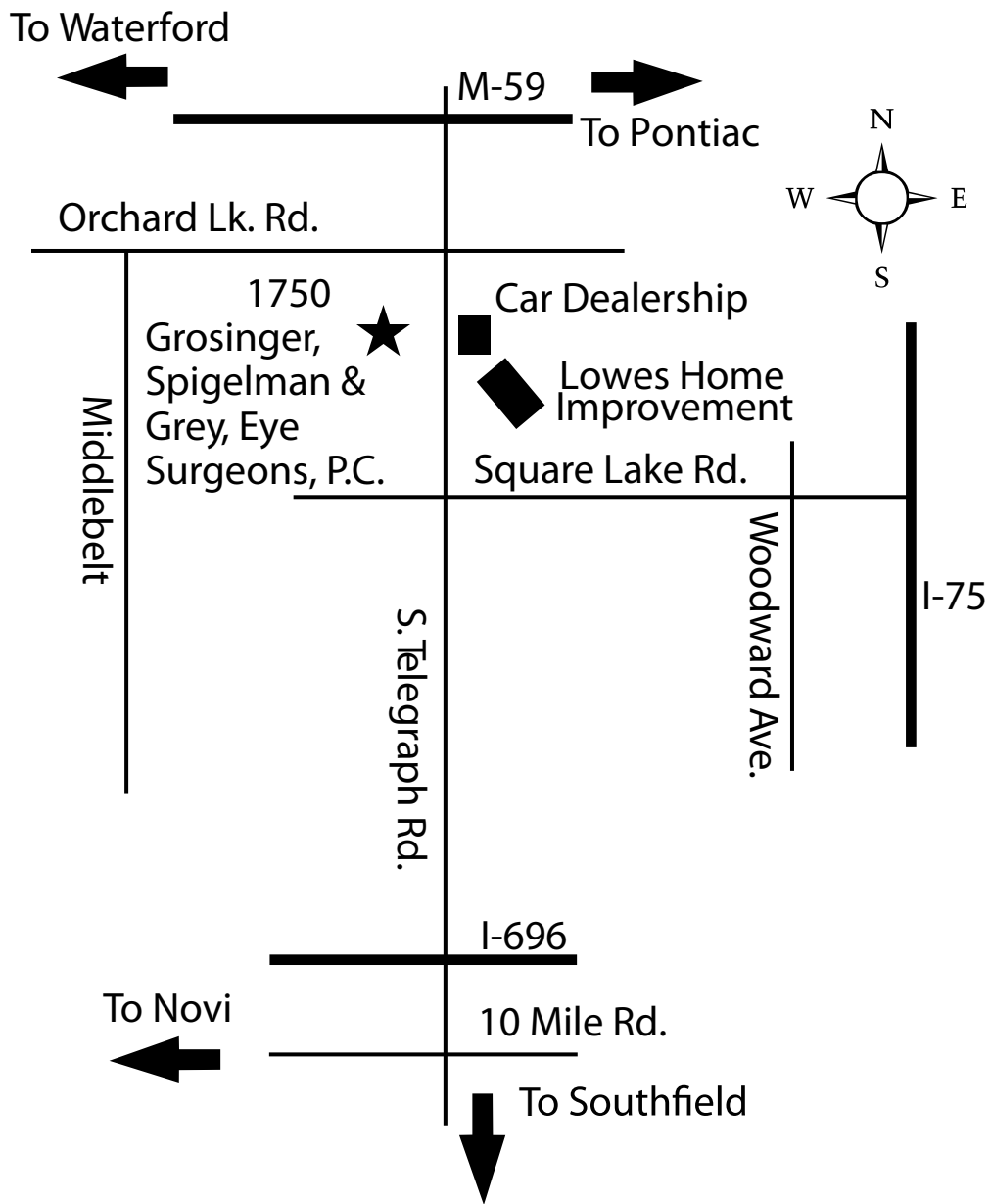
Enclosed you will find: a map to the office, a new patient data form, and possibly a medicare consent form. Please fill out the patient data form in full and bring it with you to your appointment. You should also bring the following items: a list of all current medications, sunglasses (if you have them), all insurance cards so we may bill directly and, if you are insured by a HMO, please obtain an authorization prior to coming to the office. This referral/authorization may be mailed prior to your appointment, faxed or hand delivered to our office.

Your visit to the office will be approximately 1 1/2 - 2 hours. If other testing and/or procedures are necessary, your visit could run longer. Please arrange other appointments accordingly. Please keep in mind that Dr. Grosinger, Dr. Spigelman & Dr. Grey are specialists, and as specialists they do have occasional emergency visits. We apologize in advance if your appointment is delayed for this reason.

As a new patient, the doctor will be dilating your pupils. This dilation will cause your near vision to become blurry and make you sensitive to the sunlight. It is your decision to determine whether you should bring someone to drive you home.

We are located at 1750 S. Telegraph Rd., Suite 205. We are approximately 1-1/4 mile north of Square Lake Road on the west side of Telegraph, directly across from the Car dealership, between the House of Bedroom showrooms and Carl's Golfland.

If you should have any questions, please do not hesitate to contact the office between 8 am – 5 pm Monday through Thursday or 8am – 4pm on Friday at (248) 333-2900. We thank you for your attention and look forward to meeting you.



Located at 1750 S. Telegraph Road approximately
1 mile north of Square Lake Road in Bloomfield Hills

Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name (*print*) _____

Medicare Number _____

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Grosinger, Spigelman & Grey Eye Surgeons, P.C., for services furnished me by Grosinger, Spigelman & Grey Eye Surgeons, P.C. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Grosinger, Spigelman & Grey Eye Surgeons, P.C. accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Grosinger, Spigelman & Grey Eye Surgeons, P.C., if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Grosinger, Spigelman & Grey Eye Surgeons, P.C. may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Grosinger, Spigelman & Grey Eye Surgeons, P.C. for reimbursement for services rendered, and (2) any health care provider for continued patient care. Grosinger, Spigelman & Grey Eye Surgeons, P.C. may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Grosinger, Spigelman & Grey Eye Surgeons, P.C. maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Grosinger, Spigelman & Grey Eye Surgeons, P.C. has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Grosinger, Spigelman & Grey Eye Surgeons, P.C. if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES:** I understand that Grosinger, Spigelman & Grey Eye Surgeons, P.C.'s contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Grosinger, Spigelman & Grey Eye Surgeons, P.C. to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Grosinger, Spigelman & Grey Eye Surgeons, P.C., I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Grosinger, Spigelman & Grey Eye Surgeons, P.C. for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that as my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Grosinger, Spigelman & Grey Eye Surgeons, P.C. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Grosinger, Spigelman & Grey Eye Surgeons, P.C. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Beneficiary Signature or Authorized Party _____

Date _____

Prescriptions for eyeglasses are not covered by Medicare/Medical insurance.



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DISEASES & SURGERY OF THE EYE
Diplomates American Board of Ophthalmology

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____, HAVE RECEIVED A COPY OF
(PRINT NAME)
THE NOTICE OF PRIVACY PRACTICES FOR THE OFFICE OF GROSINGER,
SPIGELMAN & GREY EYE SURGEONS, P.C.

(PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE)

*(RELATIONSHIP)

(DATE)

*IF PERSONAL REPRESENTATIVE'S SIGNATURE APPEARS ABOVE, PLEASE
DESCRIBE RELATIONSHIP TO PATIENT.

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

- ___ Individual refused to sign
- ___ Communication barriers prohibited obtaining the acknowledgement
- ___ An emergency situation prevented us from obtaining acknowledgement
- ___ Other (Please Specify)

(Employee's Name Printed)

(Employee's Signature)

(Date)

MEDICAL HISTORY QUESTIONNAIRE

Date _____

Name: _____

Date of Birth: ____/____/____

Referring /Specialty Dr. _____

Primary Care Physician: _____

Pharmacy: _____ Location(street & city) _____

Drug Allergies: **Reaction** **Severity**

_____ mild / moderate / severe

_____ mild / moderate / severe

___ No known drug allergies

(Use back for any additional)

Past Ocular History: (Please mark all that apply) ☐ No history of eye problems

☐ Amblyopia (Lazy eye)

☐ Aphakia

☐ Cataracts

☐ Diabetic Retinopathy

☐ Dry Eyes

☐ Glaucoma

☐ Keratoconus

☐ Macular Degeneration

☐ Optic Neuritis

☐ Retinal Detachment

☐ Other _____

Ocular Surgeries: (Please mark all that apply) ☐ No prior ocular surgery

R - L

R - L

R - L

☐ Foreign Body Removal

☐ Punctal Plugs

☐ Cataract Surgery

☐ Blepharoplasty

☐ Retinal Surgery

☐ RK

☐ LASIK

☐ PRK

☐ Strabismus Surgery

☐ Corneal Transplant

Other _____

Current Eye Medications: (Please list dosage and frequency)

Current Eye Conditions (Check all that apply)

___ Blurred vision

___ Fluctuating vision

___ Loss of side vision

___ Double vision

___ Dryness

___ Glare/light sensitivity/halos

___ Mucous discharge

___ Redness

___ Eye trauma

___ Sandy or gritty feeling

___ Itching

___ Burning

___ Distorted vision- things look crooked

___ Drooping eyelid

___ Eye pain or soreness

___ Tired eyes, fatigue

___ Excess tearing or watering

___ Flashing lights

___ Infection of eye or lid lump

___ Floaters

Other _____

All Other Medications: (Please list dosage and frequency)

Have you ever taken Flomax? ___ yes ___ no

Name _____

Other Medical History: ☐ No history of illnesses

- | | | |
|---|---|---|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arrhythmia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Cancer Type: _____ | | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> COPD | |
| <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> Diabetes Type 2 | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Headache | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Hepatitis A / B / C | <input type="checkbox"/> Herpes Simplex | <input type="checkbox"/> Herpes Zoster / Shingles |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Histoplasmosis |
| <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Migraine | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Polymyalgia | <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Toxoplasmosis | <input type="checkbox"/> Wound Infection | |

Other _____

General Surgeries / Operations: (Please list)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History: (Check family association)

	Maternal Parent	Paternal Parent	Grandparent	Sibling
<input type="checkbox"/> Arthritis	_____	_____	_____	_____
<input type="checkbox"/> Blindness	_____	_____	_____	_____
<input type="checkbox"/> Cancer	_____	_____	_____	_____
<input type="checkbox"/> Cataracts	_____	_____	_____	_____
<input type="checkbox"/> Diabetes	_____	_____	_____	_____
<input type="checkbox"/> Glaucoma	_____	_____	_____	_____
<input type="checkbox"/> Heart Disease	_____	_____	_____	_____
<input type="checkbox"/> High Blood Pressure	_____	_____	_____	_____
<input type="checkbox"/> Kidney Disease	_____	_____	_____	_____
<input type="checkbox"/> Lazy Eye	_____	_____	_____	_____
<input type="checkbox"/> Macular Degeneration	_____	_____	_____	_____
<input type="checkbox"/> Retinal Disease	_____	_____	_____	_____
<input type="checkbox"/> Stroke	_____	_____	_____	_____
<input type="checkbox"/> TB	_____	_____	_____	_____

Other _____

Name _____

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)

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

Skin

- ☐ Rash / Sores
- ☐ Lesions
- ☐ Hives / Eczema

Neurological

- ☐ Seizures
- ☐ Weakness / Paralysis
- ☐ Numbness
- ☐ Tremors
- ☐ Memory difficulty

Immunologic

- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

MusculoSkeletal

- ☐ Stiffness
- ☐ Arthritis
- ☐ Joint Pain / Swelling

Patient Signature _____ Date _____