DISEASES & SURGERY OF THE EYE

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Diplomates American Board of Ophthalmology

Dear New Patient:

Welcome to the practice of **Grosinger, Spigelman & Grey Eye Surgeons**.

Enclosed you will find: a map to the office, a new patient data form, a medical history form and possibly a medicare consent form. Please fill out these forms in full and mail, fax or email them to us prior to your appointment. The email address is ***gsgeyemd@gmail.com***. Please do not wear perfume, cologne or strong scented lotion to your appointment.

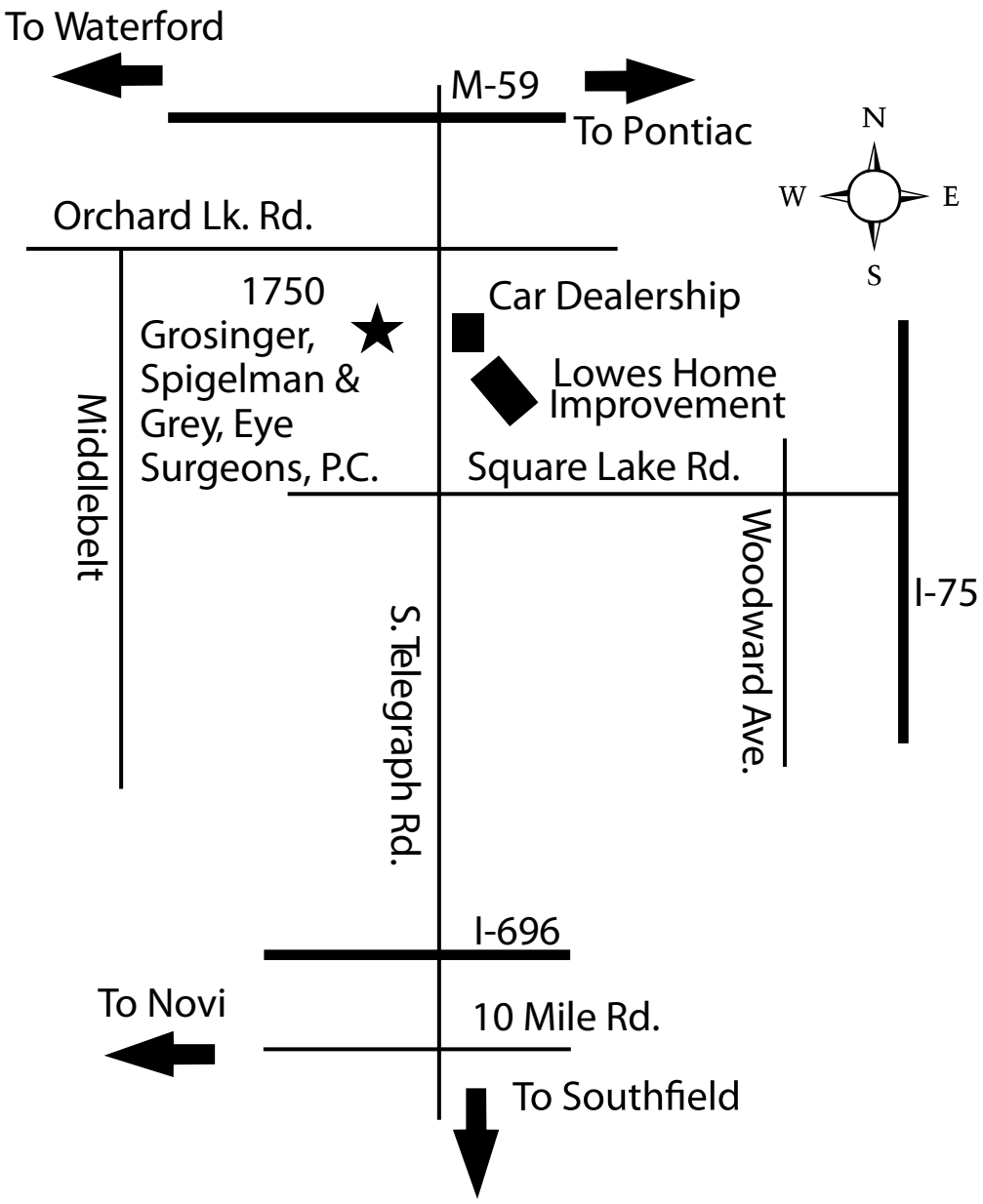
You should also bring the following items: a list of all current medications including strength and dosage, sunglasses (if you have them), all insurance cards so we may bill directly and, if you are insured by a HMO, please obtain an authorization prior to coming to the office. This referral/authorization may be mailed prior to your appointment, faxed or hand delivered to our office.
Please understand that you will be responsible for co-pays or deductibles as dictated by your insurance.

Please arrive at your scheduled appointment time. Arriving early will extend your wait time. If you are late, we may have to reschedule your appointment. Your visit to the office will be approximately 2 hours. If other testing and/or procedures are necessary, your visit could run longer. Please arrange other appointments accordingly. Please keep in mind as specialists, the doctors 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 8 am - 4 pm on Friday.
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.

NOTICE OF PRIVACY PRACTICES
Grosinger, Spigelman & Grey Eye Surgeons, P.C.
1750 Telegraph Rd, Suite 205
Bloomfield Hills, MI 48302
Amy Kesteloot, Administrator 248-333-2900

Effective Date: 12/6/2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate Grosinger, Spigelman & Grey Eye Surgeons, P.C. properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How Grosinger, Spigelman & Grey Eye Surgeons, P.C. May Use or Disclose Your Health Information.

Grosinger, Spigelman & Grey Eye Surgeons, P.C. collects health information about you and stores it in a chart and on a computer and in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

1. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
2. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.]
3. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone. As a service to our clients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.
4. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
5. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
6. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
7. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
8. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
9. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
10. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
11. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
12. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
16. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.
17. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
18. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
19. Change of Ownership. In the event that Grosinger, Spigelman & Grey Eye Surgeons, P.C. is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
20. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]
21. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When Grosinger, Spigelman & Grey Eye Surgeons, P.C. May Not Use or Disclose Your Health Information Except as described in this Notice of Privacy Practices, Grosinger, Spigelman & Grey Eye Surgeons, P.C. will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize Grosinger, Spigelman & Grey Eye Surgeons, P.C. to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that Grosinger, Spigelman & Grey Eye Surgeons, P.C. does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent Grosinger, Spigelman & Grey Eye Surgeons, P.C. has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints about this Notice of Privacy Practices or how Grosinger, Spigelman & Grey Eye Surgeons, P.C. handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:
Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave. - Suite 240
Chicago, IL 60601
(800) 368-1019 (toll free); TDD (800) 537-7697 (toll free)
(312) 886-1807 FAX
OCRcomplaint@hhs.gov**OCRMail@hhs.gov**

For a larger version of this form, please visit our website at:

www.eyemichigan.com

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

By signing this form, you acknowledge that you have received **Grosinger, Spigelman & Grey Eye Surgeons, P.C.** *Notice of Privacy Practices* containing a more complete description of how your health information may be used or disclosed. This notice discusses your rights and our duties with respect to your protected health information.

Name (Please Print):_____Date of Birth: _____/_____/_____

Patient Signature:_____Date: _____/_____/_____

Legal Guardian Signature:_____Date: _____/_____/_____

Relationship to Patient:_____

OFFICE USE ONLY: If patient refused or was unable to acknowledge the Notice of Privacy Practices, please document why acknowledgement could not be obtained. More than one attempt must be made.

Date:	***Initials:***	***Reason:***
Date:	***Initials:***	***Reason:***

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or a communication of PHI be made by means such as sending correspondence to an address other than home.

I wish to be contacted in the following manner (please check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number _____

☐ Other _____

CONSENT TO DISCLOSE MEDICAL INFORMATION TO FAMILY OR OTHER

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Name:_____ Date of Birth:_____ Relation:_____

Name:_____ Date of Birth:_____ Relation:_____

Name:_____ Date of Birth:_____ Relation:_____

_____ I request that my Protected Health Information be disclosed **ONLY** to me. I understand that <u>no information</u> regarding medical records, appointments, or billing information will be shared with anyone, other than myself.

Name (Please Print):_____Date of Birth: _____/_____/_____

Patient Signature:_____Date: _____/_____/_____

MEDICAL HISTORY QUESTIONNAIRE Date _____

Birthday _____

Name: _____

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) ☐ Do you wear contact lenses?

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	**Date**	**R - L**	**Date**	**R - L**	**Date**
☐ ☐ Foreign Body Removal	____	☐ ☐ Punctal Plugs	____	☐ ☐ Cataract Surgery	____
☐ ☐ Blepharoplasty	____	☐ ☐ Retinal Surgery	____	☐ ☐ RK	____
☐ ☐ LASIK	____	☐ ☐ PRK	____	☐ ☐ Strabismus Surgery	____
☐ ☐ Corneal Transplant	____	☐ ☐ Other Lasers	_____	☐ ☐ Other _____	

Current Eye Medications: (Please list dosage and frequency) Including over the counter.

_____ _____ _____

_____ _____ _____

Current Eye Conditions (Check all that apply) ☐ No current eye conditions

___ Blurred vision
___ Double vision
___ Mucous discharge
___ Sandy or gritty feeling
___ Distorted vision (things look crooked)
___ Eye pain or soreness
___ Flashing lights
___ Fluctuating vision
___ Dryness
___ Redness
___ ltching
___ Tired eyes, fatigue
___ lnfection of eye or lid lump
___ Loss of side vision
___ Glare/light sensitivity/halos
___ Eye trauma
___ Burning
___ Drooping eyelid
___ Excess tearing or watering
___ Floaters

Other _____

All Other Medications: (Please list dosage strength and frequency) ☐ None

_____ _____ _____

_____ _____ _____

Have you ever taken Flomax? ____ yes ____ no

Name: _____

Other Medical History: ☐ No history of illnesses

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

Other _____

All Past General Surgeries / Operations: (Please list) ☐ No history of surgeries

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family History: **(Check family association)** ☐ None ☐ Unknown

	Maternal Parent	Paternal Parent	Grandparent	Sibling
☐ Arthritis	_____	_____	_____	_____
☐ Blindness	_____	_____	_____	_____
☐ Cancer	_____	_____	_____	_____
☐ Cataracts	_____	_____	_____	_____
☐ Diabetes	_____	_____	_____	_____
☐ Glaucoma	_____	_____	_____	_____
☐ Heart Disease	_____	_____	_____	_____
☐ High Blood Pressure	_____	_____	_____	_____
☐ Kidney Disease	_____	_____	_____	_____
☐ Lazy Eye	_____	_____	_____	_____
☐ Macular Degeneration	_____	_____	_____	_____
☐ Retinal Disease	_____	_____	_____	_____
☐ Stroke	_____	_____	_____	_____
☐ 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?

_____

Recreational Drug Use: ☐ Yes ☐ No If yes, what and how often?

_____

Review of Systems: (Please mark all that apply) ☐ None

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

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 Easily
- ☐ 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: _____

Grosinger, Spigelman & Grey Eye Surgeons, P.C.

PATIENT INFORMATION

Patient Name	Prefix (circle one): Mr Mrs. Ms.	Preferred Name

Date of Birth	Social Security #	Marital Status S M D W

Street Address

City	State	Zip

CONTACT INFORMATION
(Please check your preferred contact number)

☐ Home	☐ Cell	☐ Work

Employer	Email address

REFERRAL INFORMATION

☐ Website/Internet	☐ Doctor/Optometrist	☐ Existing patient	☐ Other

Please provide the name of the provider or patient so that we may thank them:

IN CASE OF AN EMERGENCY
(Please provide the name of an emergency contact)

Emergency Contact Name	Relationship to patient

Home Phone	Cell Phone

INSURANCE INFORMATION
(Please give your insurance card to the receptionist)

Name of primary insurance company

Subscriber's Name	Subscriber's Date of Birth	Subscriber's Social Security #

Group Name	Group #	Subscriber Id#

Patient's relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance company (If Applicable)

Subscriber's Name	Subscriber's Date of Birth	Subscriber's Social Security #

Group Name	Group #	Subscriber Id#

Patient's relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

It is my responsibility to provide all necessary insurance information to process payment of my claim. I authorize payment of my insurance benefits to be made directly to my doctor. As a courtesy, the doctors office will submit my claims to my insurance carriers, but I understand that I am financially responsible for all services rendered not covered or payable by my insurance carrier including deductibles, co-payments or noncovered services.

If I need an authorization/referral, it is my responsibility to obtain it from my primary care physician prior to my appointment or I will be held responsible for payment of services rendered.

Patients who have no office visit coverage or have no insurance will be expected to pay in full at the time medical services are rendered.

Signature: _____ Date: _____