DISEASES & SURGERY OF THE EYE

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.

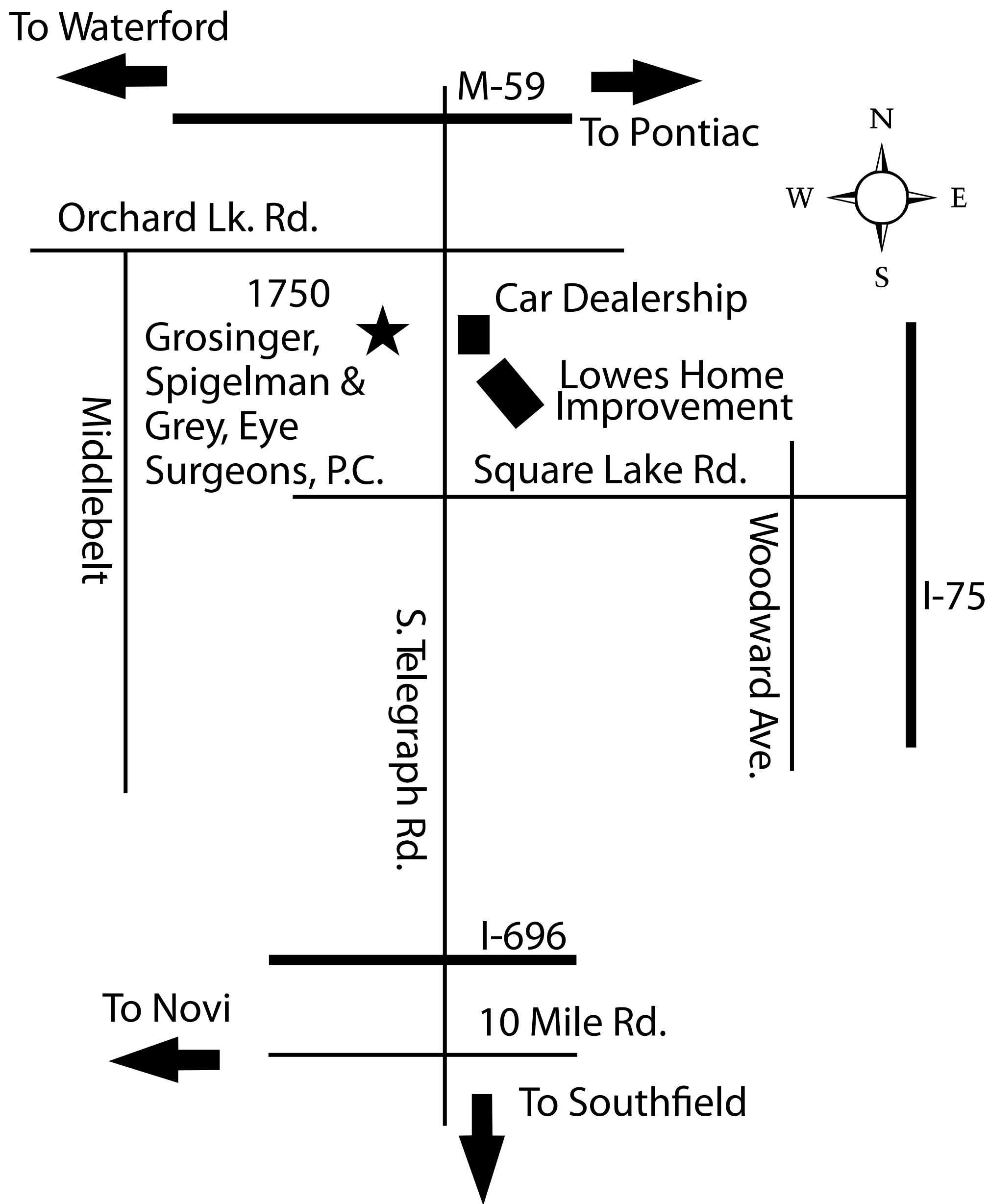
As a new patient, the doctor will be dilating your pupils. This dilation will cause your near vision to become blurry and make you sensitive to the sunlight. It is your decision to determine whether you should bring someone to drive you home.

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.

1750 S. Telegraph, Suite 205 • Bloomfield Hills, MI 48302 • (248) 333-2900

GS024 (Rev. 2/09)



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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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)

1750 S. Telegraph, Suite 205 • Bloomfield Hills, MI 48302 • (248) 333-2900

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	___ 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)	___ Tired eyes, fatigue	___ Drooping eyelid
___ Eye pain or soreness	___ Infection of eye or lid lump	___ Excess tearing or watering
___ Flashing lights		___ 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: _________________________