



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.

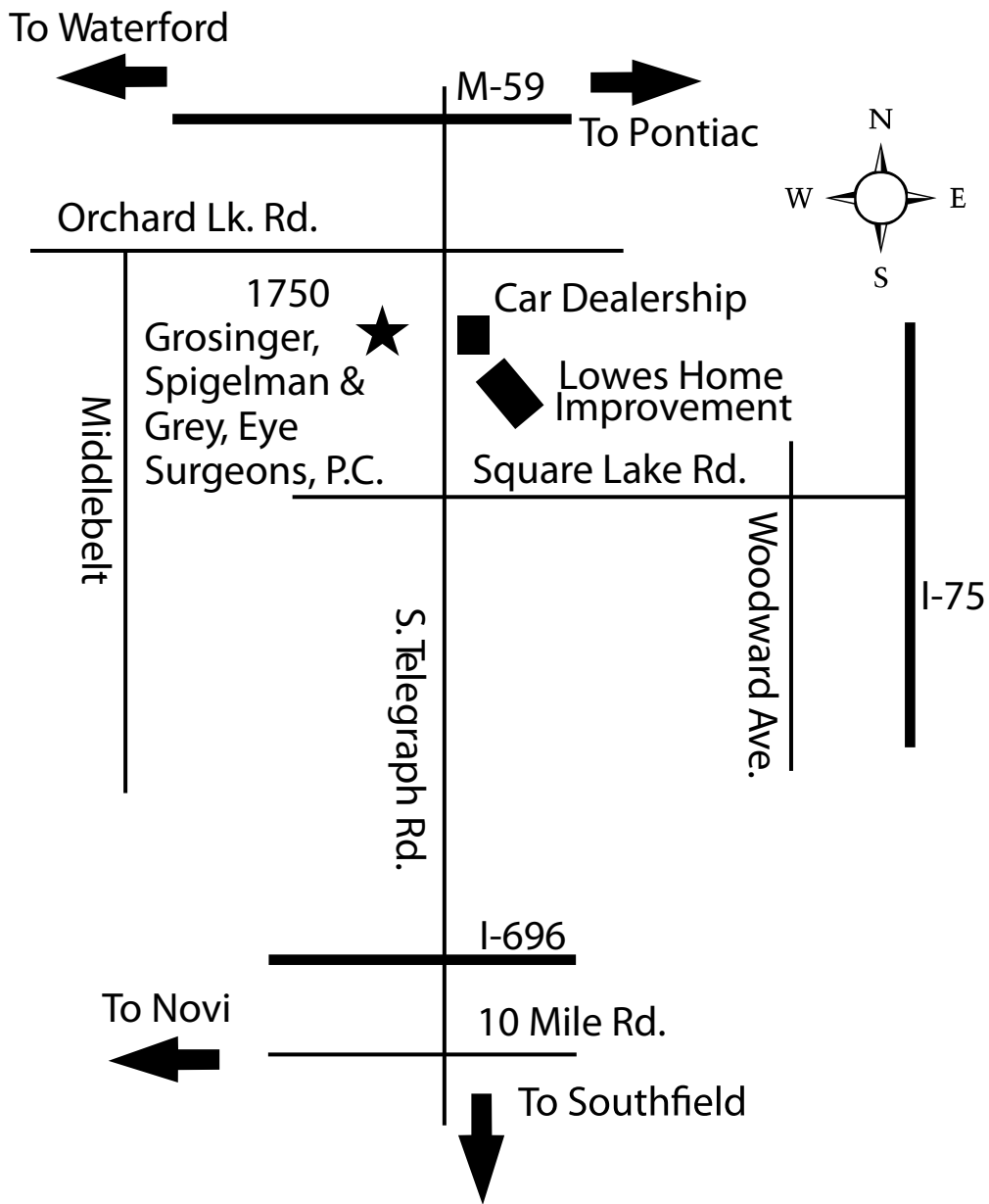
Enclosed you will find: a map to the office, a new patient data form, and possibly a medicare consent form. Please fill out the patient data form in full and bring it with you to your appointment. You should also bring the following items: a list of all current medications, sunglasses (if you have them), 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 _____

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Amblyopia (Lazy eye) | <input type="checkbox"/> Aphakia | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Keratoconus | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Optic Neuritis |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Other _____ | |

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

R - L	Date	R - L	Date	R - L	Date
<input type="checkbox"/> Foreign Body Removal	_____	<input type="checkbox"/> Punctal Plugs	_____	<input type="checkbox"/> Cataract Surgery	_____
<input type="checkbox"/> Blepharoplasty	_____	<input type="checkbox"/> Retinal Surgery	_____	<input type="checkbox"/> RK	_____
<input type="checkbox"/> LASIK	_____	<input type="checkbox"/> PRK	_____	<input type="checkbox"/> Strabismus Surgery	_____
<input type="checkbox"/> Corneal Transplant	_____	<input type="checkbox"/> Other Lasers	_____	<input type="checkbox"/> 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 | Other _____ | ___ Floaters |

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

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

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

Genito-Urinary

- Pain / Difficulty
- Blood in Urine
- History of Kidney Stones
- History of STD's

Skin

- Rash / Sores
- Lesions
- Hives / Eczema

Cardiovascular

- Chest Pain
- Dizziness
- Fainting Spells
- Shortness of Breath
- Irregular Heart Beat
- Difficulty Lying Flat

Psychiatric

- Anxiety / Depression
- Mood Swings
- Difficulty Sleeping

Neurological

- Seizures
- Weakness / Paralysis
- Numbness
- Tremors
- Memory Difficulty

Constitutional

- Fatigue / Weakness
- Fever
- Weight Gain / Loss

Endocrine

- Increased Thirst
- Increased Hunger
- Increased Urination
- Increased Sweating
- Fingernail Changes

Immunologic

- Hives
- Itching
- Runny Nose
- Sinus Pressure

Respiratory

- Cough
- Congestion
- Wheezing

Blood / Lymphnodes

- Easy Bruising
- Gums Bleed Easily
- Prolonged Bleeding

Musculoskeletal

- Stiffness
- Arthritis
- Joint Pain / Swelling

Gastrointestinal

- Heartburn
- Nausea / Vomiting
- Jaundice / Hepatitis

Patient Signature: _____ Date: _____