Christopher Singh, MD   Ankur Mehta, MD   Raafay Sophie, MD

8562 Holly Rd
Grand Blanc, Mi. 48439
Ph: 810-487-4500
Fax: 810-991-8228

5885 S. Main St. Ste. 2
Clarkston, Mi. 48346
Ph: 248-469-4600
Fax: 810-991-8228

2025 Holland Ave
Port Huron, Mi. 48236
Ph: 810-487-4500
Fax: 810-991-8228

PATIENT INFORMATION:

Last Name:___________________________________ First Name :______________________MI:_____

Mailing Address: ____Apt:_________

City:_____________________________Zip Code:______________ Home Phone:___________________

Cell/Work Phone:_______________________________Email:_________________________________

Date of Birth: ____/____/____ S.S.# ______-______-______ Occupation:________________________

Marital Status (circle one): Single Married Divorced Widowed Other

EmergencyContactName:______________________Relationship:_____________Phone:____________

DIFFERENT THAN YOURS

Who recommended you to Michigan Retina?____

PrimaryCarePhysician:_________________________________Phone:___________________________

EyeDoctor:____Phone:____________________________

Pharmacy:______________________**CROSSROADS**:_____________________Phone:_____________

[ ] Insurance [ ] Self Pay (I understand that by selecting this option, I am responsible for the full balance.)

Primary Insurance:__________________________________ Secondary Insurance:__________________

Card Holder's Name:______________DOB:________Card Holder's Name:_______________DOB:____

Relationship:__________________________________Relationship:_______________________________

If your insurance plan will not cover all or part of the fees, or if you are self-pay yourself the patient and or guardian will be responsible. Failure to pay the balance within the denoted payment period will cause the account to be sent to collections.

REFERRAL POLICY: I, the undersigned, realize that my insurance may require a referral/authorization. If it is required & not received, I understand that I am responsible for the total amount of the claims. **YOU WILL BE CHARGED A $40.00 FEE IF YOUR CHECK IS RETURNED.**

Patient or Guardian Signature X____________________________________ **Date X**_____________

MEDICARE AND MEDIGAP RELEASE:
I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS AND MEDIGAP BENEFITS BE MADE ON BY BEHALF TO THE PHYSICIANS OF MICHIGAN RETINA FOR ANY SERVICES THEY PROVIDE TO ME. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OF THE BENEFITS PAYABLE FOR RELATED SERVICES.

INSURANCE RELEASE/PATIENT RESPONSIBILITY: | REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFIT BE MADE ON MY BEHALF TO THE PHYSICIANS OF MICHIGAN RETINA FOR ANY SERVICES THEY PROVIDE TO ME. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE COMPANY ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OF THE BENEFITS PAYABLE FOR RELATED SERVICES.

| AUTHORIZE MICHIGAN RETINA TO MAKE ANY CLAIMS APPEALS TO MY INSURANCE COMPANY ON MY BEHALF. I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION REQUIRED TO ESTABLISH A HEALTH INSURANCE CLAIM. I AUTHORIZE THIS OFFICE TO OBTAIN PREVIOUS MEDICAL RECORDS FROM OTHER PHYSICIANS AND /OR MEDICAL FACILITIES, INCLUDING BUT NOT LIMITED TO INFORMATION REGARDING TREATMENT OF DRUG OR ALCOHOL ABUSE, PSYCHOLOGICAL CONDITION, HIV TESTING OR AN AIDS RELATED CONDITION.

I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ALL CHARGES INCLUDING DEDUCTIBLES, CO-PAYS, NON-COVERED SERVICES AND ANY AMOUNT NOT COVERED BY MY INSURANCE EXCEPT IN THE CASES OF CONTRACTUAL AGREEMENT BETWEEN MY INSURANCE CARRIER AND MY PHYSICIAN. **I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW AND UNDERSTAND THE COVERAGE OF MY INSURANCE PLAN AND MY FINANCIAL RESPONSIBILITY**. I UNDERSTAND THAT THE CHARGES I AM RESPONSIBLE FOR ARE TO BE PAID AT THE TIME OF SERVICE. SHOULD COLLECTION PROCEEDINGS BECOME NECESSARY, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR REASONABLE ATTORNEY FEES, COURT COSTS AND ALL COLLECTION COSTS. I AUTHORIZE CALLS TO ANY OF MY KNOWN PHONE/CELL NUMBERS IN EFFORTS TO OBTAIN PAYMENT.

| AUTHORIZE MICHIGAN RETINA, ITS STAFF OR PHYSICIANS TO CONTACT ME BY PHONE OR BY MAIL FOR THE LIMITED PURPOSE OF NOTIFYING ME FOR AN APPOINTMENT OR OTHER HEALTH CARE RELATED COMMUNICATION. THIS AUTHORIZATION ALSO INCLUDES DISCLOSURE TO THIRD PARTIES WHO ANSWER MY PHONE, LIMITED PROTECTED HEALTH INFORMATION REGARDING PENDING APPOINTMENTS, AND TO LEAVE REMINDER MESSAGE ON MY PHONE ANSWERING SYSTEM.

I HAVE RECEIVED A COPY OF THE MICHIGAN RETINA NOTICE OF PRIVACY PRACTICES

** DUE TO HIPAA REGULATIONS, WE MAY ONLY SPEAK TO OTHER HEALTH CARE PROVIDERS REGARDING YOU OR YOUR CONDITION **UNLESS** DIRECTED BY YOU. **PLEASE WRITE IN THE NAME OF THE PERSON(S) THAT YOU AUTHORIZE THE REMOVAL OF SUCH RESTRICTIONS:**

____

IN THE CASE OF MINORS: IF THE RESPONSIBLE PARTY IS SOMEONE OTHER THAN THE CUSTODIAL PARENT, WE ASK THAT THE PERSON ACCOMPANYING THE CHILD MAKE PAYMENT AT THE TIME OF SERVICE.

PLEASE NOTE: IF YOUR INSURANCE REQUIRES A REFERRAL, IT IS YOUR RESPONSIBILITY TO GET A REFERRAL FOR EACH VISIT,

PRINTED PATIENT NAME: ____

PATIENT or GUARDIAN SIGNATURE:________________________________ DATE: ____________________

THIS RELEASE FORM SHALL EXPIRE (3) YEARS FROM THE DATE OF SIGNATURE.

RETINA ASSOCIATES OF MICHIGAN

Christopher Singh, MD   Ankur Mehta, MD   Raafay Sophie, MD

Patient Name: ____________________________________

Date of Birth: ___________ **Today's Date:** _____________

Please check all of the following medical conditions that you currently have or is controlled by medication:

[ ] Anxiety	[ ] Coronary Artery Disease	[ ] High Cholesterol
[ ] Arthritis	[ ] Depression	[ ] Thyroid Disease
[ ] Asthma	[ ] Diabetes	[ ] Leukemia
[ ] Atrial Fibrillation	[ ] End Stage Renal Disease	[ ] Lung Cancer
[ ] Enlarged Prostate	[ ] GERD	[ ] Lymphoma
[ ] Bone Marrow Transplant	[ ] Hearing Loss	[ ] Prostate cancer
[ ] Breast Cancer	[ ] Hepatitis	[ ] Radiation Therapy
[ ] Colon Cancer	[ ] High Blood Pressure	[ ] Seizures
[ ] COPD	[ ] HIV / AIDS	[ ] Stroke

[ ] Other ____

Past Surgeries:

[ ] Appendectomy	[ ] Coronary Artery Bypass	[ ] Heart Transplant
[ ] Coronary Angioplasty	[ ] Cardiac Stent	[ ] Heart Valve Replacement
[ ] Kidney Removal	[ ] Kidney Biopsy	[ ] Kidney Stone Removal
[ ] Kidney Transplant	[ ] Ovary Removal (right left)	[ ] Prostatectomy
[ ] Partial Prostatectomy	[ ] Skin Biopsy Result:	[ ] Spleen Removal
[ ] Testicular Surgery	[ ] Hysterectomy	[ ] Bladder
[ ] Mastectomy (right left)	[ ] Breast Biopsy (right left)	[ ] Breast Lumpectomy (right left)
[ ] Breast Reduction	[ ] Breast Implants	[ ] Knee Replacement (right left)
[ ] Gallbladder	[ ] Colon Resection	[ ] Hip Replacement (right left)

[ ] Other ____

Ocular History:

[ ] Floaters (right left)	[ ] Vitreous Detachment (right left)
[ ] Retinal Detachment (right left)	[ ] Retinal Tear (right left)
[ ] Macular Degeneration (right left)	[ ] Epiretinal Membrane (right left)
[ ] Diabetic Retinopathy (right left)	[ ] Macular hole (right left)

[ ] Allergic Conjunctivitis	[ ] Glasses	[ ] Contact Lenses	[ ] Blepharitis
[ ] Glaucoma (right left)	[ ] Dry Eyes	[ ] Strabismus	[ ] Ophthalmic Migraine
[ ] Cataract (right left)	[ ] Narrow Angles (right left)	[ ] Corneal Dystrophy (right left)	

[ ] Other____

Ocular Surgery:

[ ] Intravitreal Injections (right left)	[ ] Retinal Laser (right left)
[ ] Cataract Removal (right left)	[ ] Blepharoplasty (right left)
[ ] Lasik Surgery (right left)	[ ] Corneal Transplant (right left)
[ ] Ptosis Repair (right left)	[ ] Eye Muscle/Strabismus Surgery
[ ] Punctal Plugs (right left)	[ ] Laser (right left)
[ ] Yag Capsulotomy (right left)	[ ] Trabeculectomy (right left)
[ ] Tube Shunt (right left)	[ ] Glaucoma surgery (right left)

[ ] Other: ____

Christopher Singh, MD   Ankur Mehta, MD   Raafay Sophie, MD

Patient Name: ____

Date of Birth: ____________ **Today's Date:** _______________

Family History: Have any of your parents, grandparents, aunts, uncles or siblings been diagnosed with any of the following:

[ ] Blindness
[ ] Glaucoma
[ ] Heart Disease
[ ] Diabetes
[ ] Macular Degeneration
[ ] Strabismus
[ ] Cancer
[ ] Stroke
[ ] Retinal Detachment
[ ] Cataracts
[ ] Hypertension
[ ] Migraine

[ ] Other____

Medications:

Name	Dosage	How Often	Name	Dosage	How Often

Allergies to Medications:

Name	Reaction	Name	Reaction

Please check here if you have no known drug allergies: [ ]

Any other allergies: ____

Social History:

Do you drink alcohol? YES/ NO If yes, how much and how often? _____________________

Do you smoke cigarettes? YES /NO If you are a former smoker, please indicate when you quit:

____

Do you use any illegal drugs? YES/ NO If yes, please specify the substance:

____

RETINA ASSOCIATES OF MICHIGAN

Christopher Singh, MD   Ankur Mehta, MD   Raafay Sophie, MD

Patient Name: ____

Date of Birth: ____________ **Today's Date:** _______________

REVIEW OF SYSTEMS - PLEASE CHECK ALL THAT APPLY

EYES
[ ] Poor vision
[ ] Eye pain
[ ] Tearing
[ ] Redness
[ ] Jaw pain
[ ] Temporary loss of vision
[ ] Loss of vision

CONSTITUTIONAL SYMPTOMS
[ ] Fever
[ ] Chills
[ ] Weight loss

ENT AND MOUTH
[ ] Stuffy nose
[ ] Ear ache
[ ] Dry mouth

CARDIOVASCULAR
[ ] Racing Pulse
[ ] High blood pressure
[ ] Irregular heartbeat

RESPIRATORY
[ ] Congestion
[ ] Wheezing
[ ] Cough/Shortness of breath

GASTROINTESTINAL
[ ] Upset stomach
[ ] Diarrhea
[ ] Constipation

GENITOURINARY
[ ] Burning on urination
[ ] Urinary frequency
[ ] Incontinence

MUSCULOSKELETAL
[ ] Joint pain
[ ] Stiffness
[ ] Arthritis

INTEGUMENTARY
[ ] Rash
[ ] Changing moles

NEUROLOGICAL
[ ] Headache
[ ] Seizure/Convulsions
[ ] Stroke
[ ] Paralysis

PSYCHIATRIC
[ ] Anxiety
[ ] Depression
[ ] Change in sleep pattern

ENDOCRINE
[ ] Diabetes
[ ] Thyroid abnormalities

HEMATOLOGIC/LYMPHATIC
[ ] Bleeding
[ ] Anemia

ALLERGIC/IMMUNOLOGIC
[ ] Allergies
[ ] Hives

[ ] Flu Vaccine Date:____________   [ ] Pneumonia Vaccine: ____________

Have you had two or more falls in the past year?

____

Is there anything else bothering you that we have not asked you about?

____

**ARE YOU CURRENTLY IN A SKILLED NURSING FACILITY? ____ IF SO, WHERE?

____

Patient's signature__________________________________ Date: ____________________