RIVERSIDE EYE CENTER / MD EYE CENTER

PATIENT REGISTRATION

Today's Date	Name (First , Middle, Last)	Date of Birth

Address	City	State	Zip Code

Male Female	White African American Hispanic Asian Native American
Sex at Birth (circle one)	Race (circle one or more)

Cell Phone	Social Security
Home Phone	Email Address

Primary Care Doctor	
Name	Address
Phone Number	Fax Number

Referring Doctor	
Name	Address
Phone Number	Fax Number

Emergency Contact	
Name	
Phone	Relationship

Pharmacy	
Name	Address
Phone	

Riverside Eye Center

4050 River Rd

Patient Health Information

Name: (Last, First, M.I.)	Birthdate	Today's Date

Thank you for taking your time to carefully complete the patient health information form. This information will be reviewed by the doctor during your examination. All information provided will be held in strict confidence.

PERSONAL MEDICAL/EYE HISTORY

Please note if you have any of the following conditions.

☐ None ☐ Diabetes ☐ High Cholesterol ☐ Macular Degeneration
☐ Cancer ☐ Arthritis ☐ Cataracts
☐ Heart Disease ☐ Dry Eye ☐ Lazy Eye
☐ High Blood Pressure ☐ Glaucoma ☐ Eye Injury
☐ Thyroid Disease ☐ Other____________________

- List major injuries and surgeries you have had. ____________________
____
- List all medications you are currently taking (prescription and over-the-counter). ____________________
____
- Do you have any allergies to medications/Latex/Dyes? ☐ Yes ☐ No If yes, please list and describe reaction.
____
- Date of your last physical exam ____________________ Are you pregnant / nursing? ☐ Yes ☐ No
- Have you had your eyes dilated? ☐ Yes ☐ No If yes, were there any problems? ____________________
- Do you wear glasses? ☐ Yes ☐ No If yes, how old are your glasses? ____________________
- Date of last complete eye exam ____________________

FAMILY MEDICAL/EYE HISTORY

Please note any family members with the following conditions. Please also note on the line next to the condition how that person is related to you.

☐ None ☐ Diabetes ____________ ☐ High Cholesterol____________ ☐ Macular Degeneration____________
☐ Cancer ____________ ☐ Arthritis ____________ ☐ Retinal disease____________
☐ Heart Disease ____________ ☐ Glaucoma ____________ ☐ Lazy Eye ____________
☐ High Blood Pressure____________ ☐ Cataracts ____________ ☐ Other____________

PERSONAL SOCIAL HISTORY

- Please list your hobbies/recreational activities. ____________________
- Do you use an electronic device at work/home? ☐ Yes ☐ No If yes, how many hours/day?____________
- Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No
- Do you use tobacco products? ☐ Yes ☐ No ☐ Previously: If yes, amount/how long?____________
- Do you drink alcohol? ☐ Yes ☐ No If yes, how often?____________
- Do you use illegal drugs? ☐ Yes ☐ No If yes, how often?____________
- Have you had a blood transfusion ☐ Yes ☐ No If yes, how recently?____________
- Have you ever been infected with the following? HIV? ☐ Yes ☐ No TB? ☐ ☐ No Hepatitis? ☐ Yes ☐ No
- Influenza vaccine received? ☐ Yes ☐ No Pneumococcal vaccine received? ☐ Yes ☐ No
- you fallen in the past 12 months? ☐ Yes ☐ No

OVER ↘

REVIEW OF SYSTEMS

Please indicate below if you currently have or have in the last month, had any of the following health signs and symptoms:

Eyes

☐ None	☐ Blurred vision	☐ Burning	☐ Eye injury	☐ Light sensitivity/glare
	☐ Loss of vision	☐ Dryness	☐ Eye pain	☐ Eye turn
	☐ Redness	☐ Excessive tears	☐ Flashes/floaters	☐ Double vision
	☐ Itching	☐ Tired/sore eyes	☐ Vision disturbance	☐ Other_________________

Constitution

☐ None ☐ Fever ☐ Weight loss ☐ Chills ☐ Other_________________

Cardiovascular

☐ None ☐ Chest pain ☐ Palpitations ☐ Lightheaded ☐ Other_________________

Ear, Nose, Mouth, Throat

☐ None ☐ Hearing loss ☐ Sinus congestion ☐ Sore throat ☐ Other_________________

Respiratory

☐ None ☐ Shortness of breath ☐ Pain when breathing ☐ Chronic cough ☐ Other_________________

Gastrointestinal

☐ None ☐ Nausea ☐ Constipation ☐ Diarrhea ☐ Other_________________

Genitourinary

☐ None ☐ Increased frequency ☐ Increased urgency ☐ Burning/itching ☐ Other_________________

Muscles/Bones/Joints

☐ None ☐ Joint pain ☐ Joint swelling ☐ Restricted motion ☐ Other_________________

Skin

☐ None ☐ Rashes ☐ Rosacea ☐ Sores ☐ Other_________________

Neurological

☐ None ☐ Headaches ☐ Seizures or Convulsions ☐ Dizziness ☐ Other_________________

Psychiatric

☐ None ☐ Anxiety ☐ Depression ☐ Memory loss ☐ Other_________________

Endocrine

☐ None ☐ Frequent urination ☐ Elevated blood sugar ☐ Excessive thirst ☐ Other_________________

Blood / Lymph

☐ None ☐ Bleeding disorder ☐ Swollen lymph nodes ☐ Low blood count ☐ Other_________________

Allergic / Immunologic

☐ None ☐ Seasonal allergies ☐ Suppressed immune system ☐ Allergic rhinitis ☐ Other_________________

Please explain any of the signs and symptoms that you checked above:

____

____

____

Riverside Eye Center / MD Eye Center

Advanced Beneficiary Notice (ABN)

Patient Name ____ **Date** ______________

Privacy Disclosure

You have the opportunity to object to and revoke the disclosure of my protected health information at any time, but by signing below, I agree to give Riverside Eye Center / MD Eye Center and its staff members permission to use and disclose my protected health information to our staff, other practitioners, insurers, public health agencies, and when required by law. You agree to have us call you regarding your treatment, insurance and or billing information, normal test results and appointment dates. I understand that a message may be left by voice mail, sent by fax, emailed, or left with a family member of your choosing. By submitting this form, I consent to receive SMS text messages from Riverside Eye Center for appointment reminders, marketing messages, and general two-way communication. Msg frequency varies. Msg & data rates may apply. Reply HELP for support. Reply STOP to opt out. Consumer information is not shared with third-parties for marketing purposes.

One Time Authorization Agreement

I request that payment of authorized insurance benefits be made to Riverside Eye Center / MD Eye Center for any services furnished to me by this provider. I authorize any holder of medical or other information about me to be released to my insurer and their agents. This includes any information needed to determine these benefits or related services. I permit a copy of the authorization to be used in place of the original. If my insurance fails to pay for a service I understand that I may be responsible for those charges.

Glasses Prescription Agreement

If you are interested in getting your prescription for glasses there may be a $49 charge. This test is considered an “elective procedure”, therefore most medical insurances will not cover it. **However, If you are here for a routine eye exam and have separate optical insurance like VSP or Eyemed, the prescription is included with your exam copay and you can ignore this section.** We cannot bill optical and medical insurance on the same day so if you are here for a medical exam and would still like to get a prescription for glasses, the charge is $49 and will be due today in our optical department. Otherwise you can schedule a separate routine exam with our optometrist. Please indicate your choice below.

☐ I want to receive this service.

☐ I have decided not to receive the service.

☐ I am using vision insurance today because I am here for a routine exam.

Patient Signature ____ **Date** ______________

Riverside Eye Center / MD Eye Center
HIPAA / Release of Medical Information

May we give your test results and any medical information to another person if you are not available?

Yes _____No _____

If Yes, please list their name and phone number below

____

____

May we leave results on your voicemail and/or answering machine?

Yes _____No _____

Riverside Eye Center
4050 River Rd
East China, MI 48054
Phone: 810-329-9045
FAX: 810-329-8732

Riverside Eye Center
4656 24th Ave
Fort Gratiot, MI 48059
Phone: 810-385-3600
FAX: 810-385-0603

MD Eye Center
17900 23 Mile Rd, Ste 100
Macomb, MI 48044
Phone: 586-416-1544
FAX: 586-416-1545

____
Email

____
Patient or Guardian Signature Date