



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 Sex at Birth (circle one)	White African American Hispanic Asian Native American Race (circle one or more)
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Cell Phone
Home Phone

Social Security
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	



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?
Date of your last physical exam Are you pregnant / nursing?
Have you had your eyes dilated?
Do you wear 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?
Do you drive?
Do you use tobacco products?
Do you drink alcohol?
Do you use illegal drugs?
Have you had a blood transfusion
Have you ever been infected with the following?
Influenza vaccine received?
you fallen in the past 12 months?

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

- | | | | | |
|-------------------------------|---|--|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Burning | <input type="checkbox"/> Eye injury | <input type="checkbox"/> Light sensitivity/glare |
| | <input type="checkbox"/> Loss of vision | <input type="checkbox"/> Dryness | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Eye turn |
| | <input type="checkbox"/> Redness | <input type="checkbox"/> Excessive tears | <input type="checkbox"/> Flashes/floaters | <input type="checkbox"/> Double vision |
| | <input type="checkbox"/> Itching | <input type="checkbox"/> Tired/sore eyes | <input type="checkbox"/> Vision disturbance | <input type="checkbox"/> Other _____ |

Constitution

- | | | | | |
|-------------------------------|--------------------------------|--------------------------------------|---------------------------------|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Fever | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Chills | <input type="checkbox"/> Other _____ |
|-------------------------------|--------------------------------|--------------------------------------|---------------------------------|--------------------------------------|

Cardiovascular

- | | | | | |
|-------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Lightheaded | <input type="checkbox"/> Other _____ |
|-------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|--------------------------------------|

Ear, Nose, Mouth, Throat

- | | | | | |
|-------------------------------|---------------------------------------|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Other _____ |
|-------------------------------|---------------------------------------|---|--------------------------------------|--------------------------------------|

Respiratory

- | | | | | |
|-------------------------------|--|--|--|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pain when breathing | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Other _____ |
|-------------------------------|--|--|--|--------------------------------------|

Gastrointestinal

- | | | | | |
|-------------------------------|---------------------------------|---------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Nausea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Other _____ |
|-------------------------------|---------------------------------|---------------------------------------|-----------------------------------|--------------------------------------|

Genitourinary

- | | | | | |
|-------------------------------|--|--|--|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Increased frequency | <input type="checkbox"/> Increased urgency | <input type="checkbox"/> Burning/itching | <input type="checkbox"/> Other _____ |
|-------------------------------|--|--|--|--------------------------------------|

Muscles/Bones/Joints

- | | | | | |
|-------------------------------|-------------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Restricted motion | <input type="checkbox"/> Other _____ |
|-------------------------------|-------------------------------------|---|--|--------------------------------------|

Skin

- | | | | | |
|-------------------------------|---------------------------------|----------------------------------|--------------------------------|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Rashes | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Sores | <input type="checkbox"/> Other _____ |
|-------------------------------|---------------------------------|----------------------------------|--------------------------------|--------------------------------------|

Neurological

- | | | | | |
|-------------------------------|------------------------------------|--|------------------------------------|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures or Convulsions | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Other _____ |
|-------------------------------|------------------------------------|--|------------------------------------|--------------------------------------|

Psychiatric

- | | | | | |
|-------------------------------|----------------------------------|-------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Other _____ |
|-------------------------------|----------------------------------|-------------------------------------|--------------------------------------|--------------------------------------|

Endocrine

- | | | | | |
|-------------------------------|---|---|---|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Elevated blood sugar | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Other _____ |
|-------------------------------|---|---|---|--------------------------------------|

Blood / Lymph

- | | | | | |
|-------------------------------|--|--|--|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Swollen lymph nodes | <input type="checkbox"/> Low blood count | <input type="checkbox"/> Other _____ |
|-------------------------------|--|--|--|--------------------------------------|

Allergic / Immunologic

- | | | | | |
|-------------------------------|---|---|--|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Suppressed immune system | <input type="checkbox"/> Allergic rhinitis | <input type="checkbox"/> Other _____ |
|-------------------------------|---|---|--|--------------------------------------|

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



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

Optomap Agreement

4050 River Rd
East China, MI
48054
810-329-9045

4656 24th Ave
Fort Gratiot, MI
48059
810-385-3600

17900 23 Mile Rd
STE 100
Macomb, MI 48044
586-416-1544

Patient Name _____ Date _____

Optomap Agreement

Optomap ultra-widefield retinal imaging can assist your eyecare professional to identify potential ocular health issues. Getting an optomap image is fast and painless. Under normal circumstances we dilate every patient. **This test replaces dilating drops to help alleviate blurred vision and light sensitivity that can occur with their use.** The image capture takes less than a half-second and they are available immediately for you to see your own retina.

The benefits of having an Optomap ultra-widefield retinal image taken are:

No dilating of your eyes.

Optomap facilitates early protection from vision impairment or blindness.

Early detection of life-threatening diseases like cancer, stroke, and cardiovascular disease.

The unique optomap ultra-widefield view helps your eye care practitioner detect early signs of retinal disease more effectively and efficiently than with traditional eye exams.

Early detection means successful treatments can be administered and reduces the risk to your sight and health.

The charge for an Optomap is \$40. Indicate below if you elect this service.

I want to receive this service. I understand that payment is due when the service is rendered.

I have decided not to receive the service.

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